N432 Care Plan #3

Lakeview College of Nursing

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N432 Care Plan and Grading Rubric

Instructions: The care plan is to be typed into a WORD document and submitted to the labor & Delivery or Postpartum Drobox within 72 hours after your clinical has ended. Be sure and compare your work with the attached rubric before submitting this to the dropbox. The care plan is worth 150 points. In order to pass you must achieve at least 116 points to acquire a pass. If you do not pass, you will have one opportunity to do a newborn care plan on a different patient. You must pass the care plan in order to pass your clinical and thus your course.

Demographics (3 points)

Date of Admission & Time of Admission 10/04/19	**Patient Initials** C.B.	**Age** 22	**Gender** Female
Race/Ethnicity African-American	**Occupation** Restaurant Employee	**Marital Status** Single	**Allergies** NDKA
Code Status Full Code	**Height** 62.5”	**Weight** 194 lbs.	**Father of Baby involved** No

Medical History (5 Points)

Prenatal History: History of pre-eclampsia with severe features (08/05/19); Late prenatal care established at 30.2 weeks (08/05/19); History of Lupus with pericardial effusion and SSA/SSB highly elevated (08/05/19); History of C-section 2016 due to pre-eclampsia with severe features (08/05/19); Anemia—Hgb 9.9—started on iron, will repeat CBC at 34 weeks (08/05/19); Chlamydia 2014 (09/06/19); RUQ pain—symptoms consistent with gallbladder dysfunction—avoid fatty, greasy, fried foods (09/18/19).

Past Medical History: Bipolar 1 disorder (HCC); Obesity; Papular atopic dermatitis (10/09/14); Psoriasis and similar disorder; Systemic lupus erythematosus (HCC); History of pericardial effusion

Past Surgical History: Pericardium surgery (07/07/2018); Cesarean section

Family History: Sister has diabetes mellitus

Social History (tobacco/alcohol/drugs): Denies tobacco use; Denies alcohol use; Denies illicit drug use

Living Situation: Lives at home with Mom

Education Level: High School

Admission Assessment (12 points)

Chief Complaint (2 points): Low transverse, C-section pain

Presentation to Labor & Delivery (10 points): Postpartum patient is a 22 year old African-American female who showed signs of low transverse fetal lie. She was complaining of labor pain upon admission to Labor & Delivery. Gestation was at 39 weeks and 0 days, and she delivered a healthy baby girl. After delivery via C-section, she complained of having low transverse abdominal pain. Upon assessment patient is A&O x 4, appears stated age, capillary refill <3 seconds, PWD, skin turgor normal, with no noted lesions or rashes. Braden scale of 21 indicates patient is at no risk for developing a pressure ulcer, and a Morse fall score of 30 indicates low fall risk. The patient shows no signs of distress.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Lupus with positive SSA and SSB antibodies

Secondary Diagnosis (if applicable): N/A

Stage of Labor (20 points):

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

According to our textbook, “Labor is typically divided into four stages: dilation, expulsive, placental, and restorative.” (Ricci et al., 2017). The first stage of labor begins with true contractions, which are stronger contractions that last about 30-90 seconds. True contractions depend on phase and come at regular intervals (frequency), and it is the longest-lasting stage. Within this first stage there are three phases: latent, active, and transition. The latent phase is the onset of labor. The expected effacement & dilation of the cervix is 1-3cm. The predicted frequency of contractions is between 5-30 minutes apart, and mild to moderate in strength. The duration of contractions lasts between 30-45 seconds long. The mother is usually talkative and eager at this phase of the first stage (Ricci et al., 2017). The active phase is when labor occurs. The expected effacement and dilation is 4-7cm. The predicted frequency of contractions is between 3-5

minutes apart, more regular, and with moderate to strong contractions. The duration of contractions lasts between 40-70 seconds long. The mother can have feelings of helplessness, anxiety, and restlessness with rapid dilation and effacement. The transition phase is the transitioning from labor to birth. The expected effacement and dilation of the cervix are between 8-10cm (complete dilation). The predicted frequency of contractions is between 2-3 minutes apart and is very strong. The duration of contractions lasts between 45-90 seconds long. The mother is tired, restless, irritable, and may feel that she cannot continue. Increased bloody show is expected to be seen during the transition (Ricci et al., 2017).

The second stage of labor lasts from 10cm dilation of the cervix to birth. The expected frequency of contractions is between 1-2 minutes apart, with the mother's pushing resulting in birth. The third stage is the birth of the infant to placental separation. The fourth stage last 1-4 hours after delivery of the neonate, and includes the delivery of the placenta, and the mother's vital signs begin to stabilize (Ricci et al., 2017). It is the nurse's responsibility to assess vital signs and fetal heart rates (FHR), assess uterine contraction characteristics, monitor the intrauterine pressure catheter (IUPC), and perform a vaginal examination throughout the stages of labor (Henry et al., 2016).

The nursing assessments and interventions also include monitoring maternal vital signs, fundus, lochia, perineum, urinary output, as well as, promoting maternal/newborn baby-friendly activities (Henry et al., 2016). Assessments for the 4th stage of labor include: blood pressure monitoring at least every 15 minutes for the first 2 hours after birth and temperature check every 4 hours for the first 8 hours postpartum, and then at least every 8 hours after; assess the fundus and lochia every 15 minutes for the first hour and then according to facility protocol; massage the uterine fundus and/or administer oxytocic as prescribed to maintain uterine tone to prevent hemorrhage; assess perineum and provide comfort measures as indicated; encourage voiding to avert bladder distention; and promote an opportunity for maternal/newborn bonding, such as skin-to-skin contact (Henry et al., 2016).

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

Henry, N., McMichael, M, Johnson, J., DiStasi, A., Roland, P., Wilford,K., and Barlow, M. (2016). ATI: RN Maternal Newborn Nursing (Edition 10). Assessment Technologies Institute, LLC.

Ricci, Kyle, T. and Carman, S. (2017). *Maternity and Pediatric Nursing* (3rd ed.).

Philadelphia: Lippincott, Williams & Wilkins.

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	3.9–5	3.59	3.79	2.58	Blood loss due to C-section delivery
Hgb	11-15.5	9.8	10.6	7.4	Blood loss due to C-section delivery
Hct	33.2-45.3%	29.9	31.1	21.0	Blood loss due to C-section delivery
Platelets	150-400(k)	281	322	200	
WBC	5-10(k)	5.4	9.1	7.1	
Neutrophils	45-80%	75.0	76.0	74.1	
Lymphocytes	11.8-46	12.0	12.9	11.9	
Monocytes	4.4-12	11.0	10.1	11.6	
Eosinophils	0-6.3	1.0	0.3	1.9	
Bands	0-1.0	1.0	0.7	0.5	

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	N/A	O-	O-	O-	
Rh factor	Negative	Negative	Negative	Negative	
Serology (RPR/VDRL)	Negative	Negative	Negative	Negative	

Rubella Titer	Immune	Immune	Immune	Immune	
Hct & Hgb	N/A	N/A	N/A	N/A	
HIV	Negative	Negative	Negative	Negative	
HbSAG	Nonreactive	Nonreactive	Nonreactive	Nonreactive	
Group Beta Strep Swab	Negative	Negative	Negative	Negarive	
Glucose at 28 weeks	70-99	N/A	N/A	N/A	
Genetic testing: if done	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	Straw/Clear	N/A	N/A	Straw/Clear	
pH	4.5-8	N/A	7.0	N/A	
Specific Gravity	1.003-1.030	N/A	1.003	N/A	
Glucose	< 0.8	N/A	Negative	N/A	
Protein	1-15 mg/dL	N/A	Negative	N/A	
Ketones	0.6-1.5	N/A	Negative	N/A	
WBC	5-10(k)	N/A	6-10	N/A	
RBC	3.9-5	N/A	Occassional	N/A	Blood loss due to C-section delivery
Leukoesterase	N/A	N/A	N/A	N/A	

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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	Straw/Clear		Unclear		Mixed growth of one or more distal urethral contaminants (11/23/18).

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	

Lab Correlations Reference (APA):

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's Textbook of Medical Surgical Nursing (14th ed.).* Philadelphia, PA: Wolters Kluwer Health Lippincott William & Wilkins.

Normal Lab Values - Common Laboratory Values. (n.d.). Retrieved from https://www.meditec.com/resourcestools/medical-reference-links/normal-lab-values/

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	Your Assessment
	Electronic fetal heart monitoring (EFHM) is a procedure used to evaluate the well-being of the fetus by assessing the heart rate and rhythm of the fetal heartbeat. EFHM gives evidence of fetal well-being and oxygenation during labor and reduces the incidence of poor neonatal outcomes

	(Stanford Children's Health, 2019). Components of EFHM may include external or internal devices (Stanford Children's Health, 2019). External devices, such as a hand-held Doppler ultrasound device, ultrasound stethoscope, or fetoscope, can be used to assess fetal heart rate (FHR). In conjunction, palpation of contractions at the fundus for frequency, intensity, duration, and resting tone is used to evaluate fetal well-being (Henry et al., 2016). Continuous electronic fetal monitoring uses an ultrasound transducer over the patient's abdomen to record the FHR pattern, and a toco transducer on the fundus that records the uterine contractions (Henry et al., 2016). Continuous internal fetal monitoring uses a scalp electrode that is attached to the presenting part of the fetus to monitor the FHR. The electrode wires are then attached to a leg plate that is placed on the patient's thigh and then attached to the fetal monitor (Henry et al., 2016). The FHR tracing includes a three-tier interpretation system broken into three categories that define the severity of FHR and what causes it. Category 1 FHR tracings are healthy and do not require intervention. Tracings contain: Baseline fetal heart rate of 100 to 160 beats per minute; Baseline fetal heart rate variability: moderate; Accelerations: present or absent; early decelerations: present or absent; variable or late decelerations: absent. Category 2 FHR tracings are indeterminate and require evaluation and monitoring. Tracings contain: Baseline rate: tachycardia, and bradycardia that is not accompanied by absent baseline variability; Baseline FHR variability: Minimal baseline variability, absent baseline variability that is not accompanied by recurrent decelerations, and marked baseline variability; Episodic or periodic decelerations: prolonged fetal heart rate

	deceleration equal or greater than 2 minutes but less than 10 minutes, recurrent variable decelerations with minimal or moderate baseline variability, and variable decelerations with additional characteristics (e.g., “overshoots”, “shoulders”, or slow return to baseline FHR); Accelerations: absence of induced accelerations after fetal stimulation. Category 3 FHR tracings are abnormal and require intervention. Tracings contain: Sinusoidal pattern; Absent baseline FHR variability and any of the following: recurrent variable decelerations, recurrent late decelerations, or bradycardia; Each uterine contraction is comprised of the following: Increment: the beginning of the contraction as intensity is increasing; Acme: the peak intensity of the contraction; Decrement: the decline of the contraction intensity as the contraction is ending; Non-reassuring FHR patterns are associated with fetal hypoxia and include the following: fetal bradycardia, fetal tachycardia, absence of FHR variability, late decelerations, variable decelerations (Henry et al., 2016). Interventions for Category 3 FHR tracings include: Notifying the healthcare provider; Discontinue oxytocin or other uterotonic agents; Turn the patient onto her left or right lateral, knee-chest, or hands and knees to increase placental perfusion or relieve cord compression; Administer oxygen via nonrebreather face mask; Increase IV fluid rate to improve intravascular volume and correct maternal hypotension; Assess the patient for any underlying causes; Provide reassurance ; Modify pushing in the second stage of labor to improve fetal oxygenation; Document any and all interventions and changes in FHR pattern; Prepare for an expeditious surgical birth if the pattern is not corrected in 30 minutes (Ricci et al., 2016).
What is the Baseline	

(BPM) EFH?	The healthy baseline electronic FHR is between 110 to 160 bpm, and it tells us what the average baseline is for that particular fetus. According to Ricci, "Baseline FHR refers to the average FHR that occurs during a 10-minute segment that excludes periodic or episodic rate changes, such as tachycardia or bradycardia." (2016, p.494).
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?**	Upon my clinical assessment, the patient was postpartum and already had a cesarean delivery. However, to describe accelerations on the FHR monitor, they are short and sharp rises in the heart rate (above baseline) of at least 15 beats per minute, and are a good indication that the fetus is getting adequate oxygen. The peak of acceleration is less than 30 seconds and less than 2 minutes in duration (Henry et al., 2016).
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?**	Upon my clinical assessment, the patient was postpartum and already had a cesarean delivery. However, to describe decelerations on the FHR monitor, they are short and sharp falls in the heart rate (below baseline), and can be classified as variable decelerations, early decelerations, or late decelerations depending on their shape and association to a uterine contraction (Ricci et al., 2016). Early decelerations are usually due to compression of the fetal head during contractions, and cause the FHR to slow during contractions. Variable decelerations have an unpredictable shape on the FHR baseline, and have no fixed time relationship to uterine contractions (Ricci et al., 2016). Variable decelerations are usually caused by compression of the umbilical cord and do not indicate fetal distress. Early decelerations are

	characterized by a gradual decrease of the FHR starting at the beginning of the contraction, and returning to the baseline by the end of the contraction. The lowest point occurs at the peak of the contraction (Ricci et al., 2016). Late decelerations are characterized by the decrease in FHR that occur after the peak of the contraction, with the FHR returning to baseline 30 seconds or more after the contraction has ended (Ricci et al., 2016). Repeated late decelerations are a sign of fetal distress and are caused by fetal hypoxia. The timing of the deceleration must be carefully observed and taken seriously. Late decelerations are always a category 2 (indeterminate) or category 3 (abnormal). Interventions for Category 3 FHR tracings include: Notifying the healthcare provider; Discontinue oxytocin or other uterotonic agents; Turn the patient onto her left or right lateral, knee-chest, or hands and knees to increase placental perfusion or relieve cord compression; Administer oxygen via nonrebreather face mask; Increase IV fluid rate to improve intravascular volume and correct maternal hypotension; Assess the patient for any underlying causes; Provide reassurance ; Modify pushing in the second stage of labor to improve fetal oxygenation; Document any and all interventions and changes in FHR pattern; Prepare for an expeditious surgical birth if the pattern is not corrected in 30 minutes (Ricci et al., 2016).
Describe the contractions i.e. frequency, length, strength, patient's response.	My patient's FHR baseline rate was about 145 bpm. The frequency of contractions were about 3 minutes apart, lasted about 1 minute in duration, and reported as very strong contractions. Patient stated she could not feel any pain during the C-section, and was in a state of

	euphoria during the procedure.

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**Acetaminophen (Tylenol)**	**Ascorbic Acid (Vitamin C)**	**Azithromycin (Zithromax)**	**Clonidine (Catapres)**	**Ferrous sulfate (30% elemental iron)**
Dose	325 mg tablet	250 mg tablet	250 mg tablet	0.1 mg tablet	60 mg tablet
Frequency	Daily	Daily	Daily	Two times per day	Daily
Route	PO	PO	PO	PO	PO
Classification	Antipyretic	Water soluble vitamin	Antibiotic	Antihypertensive	Iron supplement
Mechani	Inhibits the synthesis of prostaglandins that may serve as mediators of pain and fever, primarily in the CNS. It has no significant anti-inflammatory properties or GI toxicity.	Necess	Inhibit	Stimul	An esse

sm of Acti on	Therapeutic Effects: Analgesia. Antipyresis.	ary for coll age n for mat ion and tiss ue rep air. Inv olv ed in oxi dati on red ucti on rea ctio ns; tyro sine , foli c aci d, iron , and car boh ydr ate met abo lis m; lipi d and	s pro tein syn the sis at the lev el of the 50 S bac teri al rib oso me.	ates alph a-ad rene rgic rece ptor s in the CN S, whi ch resu lts in decr ease d sym path etic outf low inhi biti ng card ioac cele rati on and vas oco nstr icti on cent ers. Pre vent s pain sign al tran	ntial min eral fou nd in hem oglo bin, myo glob in, and man y enz yme s. Ent ers the bloo dstr eam and is tran spor ted to the orga ns of the retic uloe ndot heli al syst em (liv er, sple en, bon

		protein synthesis; cellular respiration; and resistance to infection. Therapeutic Effects: Replacement in deficiency states. Supplementation during increased req		smission to the CNS by stimulating alpha-adrenergic receptors in the spinal cord.	e marrow) where it becomes part of iron stores.

		uirements.			
Reason Client Taking	Reduce mild to moderate pain	Prevent vitamin C deficiency (scurvy)	Prevent infection. Bacteriostatic action against susceptible bacteria.	Reduce hypertension	Prevent iron deficiency anemia.
Contraindications (2)	1) Hepatic impairment 2) Alcoholism	1) Large doses during pregnancy 2) Kidney stones	1) History of cholestatic jaundice or hepatic dysfunction 2) Liver	1) Pregnancy and lactation 2) Disorders of cardiac pacemaker activity and	1) Hemochromatosis 2) Hemosiderosis

			impairment	conduction	
Side Effects/Adverse Reactions (2)	1) Insomnia 2) Hepatotoxicity	1) Kidney stones 2) DVT	1) QT interval prolongation 2) Toxic Epidermal Necrolysis	1) Depression 2) hypotension (increases with epidural)	1) Syncope 2) GI bleeding
Nursing Considerations (2)	1) If overdose occurs, acetylcysteine (Acetadote) is the antidote. 2) Assess overall health status and alcohol usage before administering acetaminophen. Patients who are malnourished or chronically abuse alcohol are at higher risk of developing hepatotoxicity with chronic use of usual doses of this drug.	1) Often ordered as a part of multivitamin supplementation, because ina	1) Quinidine, procainamide, dofetilide, sotalol, and amiodarone may	1) Hypertension: Monitor intake and output ratios and daily weight, and asse	1) Use Cautiously in: Peptic ulcer disease; Ulcerative colitis or regional enteritis (con

		dequate diet often results in multiple-vitamin deficiency. 2) : Extended-release tablets and capsules should be swallowed whole without crushing, breaking,	increase the risk of QT interval prolongation; concurrent use should be avoided. 2) Nelfinavir elevates levels (monitor carefully); azithromycin als	ss for edema daily, especially at beginning of therapy 2) Monitor for fever as potential sign of catheter infection.	dition may be aggravated); Alcoholism; Severe hepatic impairment; Severe renal impairment. 2) Avoid using antacids, coffee, tea, dairy products, eggs, or whole-grain

		or chewing; contents of capsules may be mixed with jelly or jam. Chewable tablets should be chewed well or crushed before swallowing. Oral solutio	o decreases nel fin avir levels.		breads with or within 1 hr after administration of ferrous salts. Iron absorption is decreased by 33% if iron and calcium are given with meals.

		n may be taken directly by mouth or mixed with fruit juice, cereal, or other food.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1) Evaluate hepatic, hematologic, and renal function periodically during prolonged, high-dose therapy. 2) Increased serum bilirubin, LDH, AST, ALT, and prothrombin time may indicate hepatotoxicity.	1) Megadoses of ascorbic acid (>10 times the RDA requireme	1) Assess patient for infection (vital signs; appearance of wound,	1) Assess blood glucose levels. May cause transient increase in blo	1) If patient has iron deficient anemia, assess nutritional status and dietary

		nt) may cause false-negative results for occult blood in the stool. May cause decreased serum bilirubin and elevated urine oxalate, urate, and cystein e	sputum, urine, and stool; WBC) at beginning of and throughout therapy. 2) May cause elevated serum bilirubin, AST, ALT, LDH, and alkaline pho	od glucose levels. 2) May cause decreased urinary catecholamine and vanillylmandelic acid (VMA) concentrations; these may elevate on abrupt withdrawal.	history to determine possible cause of anemia and need for patient teaching. 2) Monitor hemoglobin, hematocrit, and reticulocyte values prior to and every 3 wk during the first

		levels. 2) Assess for signs of vitamin C deficiency (faulty bone and tooth development, gingivitis, bleeding gums, loosened teeth) before and during therapy.	sphatase concentrations,		2 mo of therapy and periodically thereafter. Serum ferritin and iron levels may also be monitored to assess effectiveness of therapy.

Client Teaching needs (2)	1) Advise patient to take medication exactly as directed and not to take more than the recommended amount. Chronic excessive use of 4 g/day (2 g in chronic alcoholics) may lead to hepatotoxicity, renal or cardiac damage. Adults should not take acetaminophen longer than 10 days and children not longer than 5 days unless directed by health care professional. Short-term doses of acetaminophen with salicylates or NSAIDs should not exceed the recommended daily dose of either drug alone. 2) Advise patient to avoid alcohol (3 or more glasses per day increase the risk of liver damage) if taking more than an occasional 1– 2 dosesand to avoid taking concurrently with salicylates or NSAIDs for more than a few days, unless directed by health care professional.	1) Advise patient to take medication as directed and not to exceed dose prescribed. Excess doses may lead to diarrhea and urinary stone formation. If a dos	1) Instruct patient not to take azithromycin with food or antacids. 2) Advise patient to use sunscreen and protective clothing to prevent photosensitiv	1) Encourage patient to comply with additional interventions for hypertension (weight reduction, low-sodium diet, discontinuation of smoking, moderation of alcohol con	1) Explain purpose of iron therapy to patient. 2) Advise patient that stools may become dark green or black.

		e is missed, skip dose and return to dose schedule. 2) Foods high in ascorbic acid include citrus fruits, tomatoes, strawberries, cantaloupe, and raw pepper	ity reactions.	sumption, regular exercise, and stress management). Medication helps control but does not cure hypertension. 2) Caution patient to avoid sudden changes in position to	

		s. Gradual loss of ascorbic acid occurs when fresh food is stored, but not when it is frozen. Rapid loss is caused by drying, salting, and cooking.		decrease orthostatic hypotension. Use of alcohol, standing for long periods, exercising, and hot weather may increase orthostatic hypotension.	

Hospital Medications (5 required)

Brand/Generic	Oxytocin (Pitocin)	Ferrous Sulfate (Iron)	Hydrocodone-acetaminophe	Hydroxychloroquine (Plaquenil)	Ondansetron (Zofran)

			n (Norco)		
Dose	60-300 milli-units/min	325 mg tablet/100 mg infusion	5 mg tablet	200 mg tablet	4 mg = 2 mL injectable
Frequency	Once	Daily	Every 4 hours PRN	Daily	Every 6 hours PRN
Route	IV	PO/IV	PO	PO	IV
Classification	Oxytocic (hormone)	Iron supplement	Analgesic	DMARD	Antiemetic
Mechanism of Action	Stimulates uterine smooth muscle, producing uterine contractions similar to those in spontaneous labor. It has vasopressor and antidiuretic effects.	An essential mineral found in hemoglobin, myoglobin, and many enzymes. Enters the bloodstream and is transported to the organs of the reticuloendothelial system (liver, spleen, bone marrow) where it becomes part of iron stores.	Bind to opiate receptors in the CNS. Alter the perception of and response to painful stimuli while producing generalized CNS depression: Suppress the cough reflex via direct central action. A decrease in the severity of moderate pain. Suppression of the cough reflex.	Inhibits protein synthesis in susceptible organisms by inhibiting DNA and RNA polymerase. Therapeutic Effects: Death of plasmodia responsible for causing malaria. Also has anti-inflammatory properties.	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine.
Reason Client Taking	Cause and strengthen labor contractions	Prevent iron deficiency anemia.	Reduce pain	Treat lupus	Reduce nausea
Contraindications (2)	1) Anticipated nonvaginal delivery. 2) First and second stages of labor; slow	1) Peptic ulceration 2) regional enteritis	1) Hypercarbia 2) Respiratory depression	1) Visual impairment 2) Renal impairment	1) Concomitant use of apomorphine. 2) Congenital long QT syndrome

	infusion over 24 hr has caused water intoxication with seizure and coma or maternal death due to oxytocin's antidiuretic effect.				
Side Effects/Adverse Reactions (2)	1) Maternal: hypotension 2) Fetal: intracranial hemorrhage	1) Black, tarry stool 2) Constipation	1) Lethargy 2) Peripheral edema	1) Confusion 2) Ototoxicity	1) Dystonia 2) Torsade's de pointes
Nursing Considerations (2)	1) Fetal maturity, presentation, and pelvic adequacy should be assessed prior to administration of oxytocin for induction of labor. 2) Monitor maternal BP and pulse frequently and fetal heart rate continuously throughout administration.	1) Use Cautiously in: Peptic ulcer disease; Ulcerative colitis or regional enteritis (condition may be aggravated); Alcoholism; Severe hepatic impairment; Severe renal impairment. 2) Avoid using antacids, coffee, tea, dairy products, eggs, or whole-grain breads with or within 1 hr after administration	1) Be aware that opioid therapy should only be used concomitantly with benzodiazepines in patients for whom other treatment options are inadequate. 2) Monitor patient for respiratory depression.	1) Administer with milk or meals to minimize GI distress. 2) Tablets may be crushed and placed inside empty capsules for patients with difficulty swallowing. Contents of capsules may also be mixed with a teaspoonful of jam, jelly, or Jell-O prior to administration.	1) Place disintegrating tablet or oral soluble film on patient's tongue immediately after opening package. It dissolves in seconds. 2) Use calibrated container or oral syringe to measure dose of oral solution.

		of ferrous salts. Iron absorption is decreased by 33% if iron and calcium are given with meals.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1) Monitor maternal electrolytes. Water retention may result in hypochloremia or hyponatremia. 2) Assess character, frequency, and duration of uterine contractions; resting uterine tone; and fetal heart rate frequently throughout administration. If contractions occur <2 min apart and are >50– 65 mm Hg on monitor, if they last 60– 90 sec or longer, or	1) If patient has iron deficient anemia, assess nutritional status and dietary history to determine possible cause of anemia and need for patient teaching. 2) Monitor hemoglobin, hematocrit, and reticulocyte values prior to and every 3 wk during the first 2 mo of therapy and periodically thereafter. Serum ferritin and iron levels may also be monitored to assess effectiveness of therapy.	1) May cause elevated plasma amylase and lipase concentrations 2) If an opioid antagonist is required to reverse respiratory depression or coma, naloxone is the antidote. Dilute the 0.4-mg ampule of naloxone in 10 mL of 0.9% NaCl and administer 0.5 mL (0.02 mg) by direct IVpush every 2 min. For children and patients weighing 40 kg, dilute 0.1 mg of naloxone in 10 mL of 0.9% NaCl for a concentration of 10 mcg/mL and administer 0.5mcg/kg every 2 min.	1) Monitor CBC and platelet count periodically throughout therapy. May cause decreased RBC, WBC, and platelet counts. If severe decreases occur that are not related to the disease process, hydroxychloroquine should be discontinued. 2) Assess deep tendon reflexes periodically to determine muscle weakness. Therapy may be discontinued should this occur.	1) Monitor ECG in patients with hypokalemia, hypomagnesemia, HF, bradyarrhythmias, or patients taking concomitant medications that prolong the QT interval. 2) May cause transient elevation in serum bilirubin, AST, and ALT levels.

	if a significant change in fetal heart rate develops, stop infusion and turn patient on her left side to prevent fetal anoxia. Notify health care professional immediately.		Titrate dose to avoid withdrawal, seizures, and severe pain.		
Client Teaching needs (2)	1) Advise patient to expect contractions similar to menstrual cramps after administration has started. 2) Inform patient that common side effects may include nausea and vomiting.	1) Explain purpose of iron therapy to patient. 2) Advise patient that stools may become dark green or black.	1) Instruct patient to take drug exactly as ordered and not to adjust dosage without speaking to prescriber first. 2) Urge patient to consume plenty of fluids and high-fiber foods to prevent constipation.	1) Instruct patient to take medication exactly as directed and continue full course of therapy even if feeling better. Missed doses should be taken as soon as remembered unless it is almost time for next dose. Do not double doses. 2) Advise patients to avoid use of alcohol while taking hydroxychloroquine.	1) Advise patient to use calibrated container or oral syringe to measure oral solution. 2) Advise patient to immediately report signs of hypersensitivity, such as rash.

Medications Reference (APA): (2 points)

2019 Nurse's Drug Handbook (18th ed.). (2019). Jones & Bartlett Learning.

Up-to-Date Drug Information. (2019). Retrieved from https://www.drugguide.com/ddo/

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** A&Ox4 **Orientation:** A&Ox4 **Distress:** No acute distress **Overall appearance:** Appears stated age	Patient is A&Ox4, no acute distress, and appears stated age.
INTEGUMENTARY (2 points): **Skin color:** PWD **Character:** PWD, capillary refill <3 seconds bilaterally, skin turgor is normal for age, no noted lesions or rashes. **Temperature:** 97.9 F **Turgor:** Appropriate for age **Rashes:** No noted rashes **Bruises:** No noted bruises **Wounds/Incision:** C-section **Braden Score:** 21 **Drains present: Y☒ N ☐** **Type:** Foley catheter	Skin is PWD (pink, warm and dry). Skin turgor is appropriate for age. Braden Score of 21 indicates mild no risk for developing pressure ulcers.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient has no palpable lymph nodes. Head is normocephalic and atraumatic. Eyes are PERRLA and EOMI bilaterally. TMs pearly gray bilaterally. No noted deviated septum, polyps or turbinates. Moist mucus membranes, no noted exudate, lesions, erythema around the head and neck. Trachea is midline.
CARDIOVASCULAR (1 points):	

Heart sounds: **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** RRR **Peripheral Pulses:** dorsalis pedis 2+ bilaterally **Capillary refill:** <3 seconds **Neck Vein Distention: Y ☐ N ☒ Edema Y ☐ N ☒** **Location of Edema:**	S1, S2 detected. RRR (regular, rate and rhythm). No noted murmurs, gallops, or rubs. Capillary refill less than 3 seconds. 2+ pedal pulses bilaterally. No noted deformities. No noted edema.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Lungs CTA (clear to auscultation) bilaterally. No noted wheezes, rhonchi or crackles
GASTROINTESTINAL (5 points): **Diet at home:** Regular **Current Diet:** Regular **Height:** 62.5 inches **Weight:** 194 lbs. **Auscultation Bowel sounds:** Bowel sounds present in all four quadrants **Last BM:** 10/07/19 @ 06:40 **Palpation: Pain, Mass etc.:** I did not palpate abdomen. Patient states pain (7/10) in low transverse C-section area. **Inspection:** **Distention:** abdomen (postpartum) **Incisions:** C-section **Scars:** None noted **Drains:** None noted **Wounds:** None noted	I did not palpate abdomen. Bowel sounds present in all four quadrants. Patient states pain (7/10) in low transverse C-section area.

Fundal Height & Position: 1 cm below umbilicus	
GENITOURINARY (5 Points): **Bleeding:** Scant (less than 2.5 cm on pad/hr) **Color:** Yellow **Character:** Straw/yellow/no odor **Quantity of urine:** 750 mL **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** I did not inspect genitals **Catheter: Y ☒ N ☐** **Type:** Foley catheter **Size:** 14 FR **Rupture of Membranes:** Amniotomy (AROM) **Time:** ~02:00 on 10/05/19 **Color:** Clear **Amount:** 600 mL **Odor:** None **Episiotomy/lacerations:** None	Physician performed amniotomy on patient at ~02:00 on 10/05/19 prior to C-section delivery. No noted signs of infection.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** Morse Fall Score 30 (Low Risk) **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	Patient denies using assistive devices at home. Hand grips equal bilaterally. ROM intact in the upper and lower extremities bilaterally, 5/5 musculoskeletal strength in upper and lower extremities bilaterally. Patient is a low fall risk as evidence by Morse Fall Scale of 30.

NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** A&Ox4 **Mental Status:** Patient is awake and alert **Speech:** Clear **Sensory:** Responsive to stimuli and environment **LOC:** Patient exhibits no signs of impaired memory and is oriented to person, place, time, and situation. **DTRs:** DTRs intact	MAEW bilaterally. Eyes: PERRLA and EOMI bilaterally. Pupil size is 3mm and equal, round, reactive to light with 2 step method. Patient is A&Ox4 and exhibits no signs of impaired memory and is oriented to person, place, time, and situation. DTRs intact. No sensory loss noted. CNII through XII grossly intact. Patient is awake and alert. She is responsive to stimuli. Her speech is clear.
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** Listening to music and hanging out with friends & family. **Developmental level:** High School graduate **Religion & what it means to pt.:** Christian and being kind to others. **Personal/Family Data (Think about home environment, family structure, and available family support):** Patient lives with Mother and siblings. She has another child via C-section, and family is helping her raise.	Patient's coping methods are listening to music and being with close friends and family Patient has a high school education. Patient states that she is of Christian faith. Patient is single. Patient lives with Mother and siblings. She has another child via C-section, and family is helping her raise. Patient seems to have a strong support system.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** 10/05/19 **Time:** 02:08 **Type (vaginal/cesarean):** Cesarean **Quantitative Blood Loss:** 600 mL **Male or Female:** Baby is a girl	Patient gave birth to a healthy baby girl via C-section at 02:08 on 10/05/19. Baby's weight is 2,610 g (5 lbs. 12.1 oz.). Breastfeeding is feeding of choice.

Apgars: one minute: 9; five minute: 9 **Weight:** 2,610 g **(**5 lbs. 12.1 oz.) **Feeding Method:** Breastfeeding	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	70	127/80	16	97 F	96%
Labor/Delivery	75	131/78	16	97 F	97%
Postpartum	70	113/82	16	98 F	99%

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
15:30	7/10 out of a 0-10 pain scale	C-section area	Moderate	Sharp	Analgesic administration
18:00	7/10 out of a 0-10 pain scale	C-section area	Moderate	Sharp	Analgesic administration

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** Median vein (underside of arm)	Double lumen 18 gauge located in median vein (underside of arm). Dated 10/05/19 @ 01:00. It

Date on IV: 10/05/19 **Patency of IV:** Patent and correctly placed **Signs of erythema, drainage, etc.:** No noted erythema or drainage **IV dressing assessment:** Clean, dry and intact	is being flushed every 4 hours.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360mL (PO); 750mL (IV)	750mL (urine)

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Educate the patient on the importance of follow-up care due to the many risk complications after child birth, such as excessive bleeding, formation of blood clots, pre-eclampsia, and infection. The nurse should first find out what the patient already knows, and to correct any misunderstandings. The nurse should use layman's terms and use visual aids while educating the patient. The nurse should make sure the patient understands the medications administered to them, and how and when to refill medications. The nurse should provide the patient with information about signs and symptoms of their condition that will require immediate attention. Nurses should take advantage of technology to make education materials easily accessible. The nurse should determine the patient's learning style; if the patient is more of hands on approach, or can learn best by watching a video. The nurse should establish rapport with the patient to develop trust and understand patient's concern(s). The nurse needs to consider the patient's limitations and strengths, so that the patient fully grasps the information they are receiving. Also, the nurse should include family members, or support persons in patient teaching.

2. Expected outcomes of teaching can include follow-up care compliance, medication compliance, patient is able to demonstrate the teaching, and patient is able to maintain vital signs in a healthy range.

Nursing Interventions (6 points)

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

Nursing Interventions: Monitor laboratory values, such as platelet count, activated partial thromboplastin time (APTT), fibrinogen and Fibrin degradation products (FDP). Measures severity of disseminated intravascular coagulation (DIC); determines replacement needs and effects of therapy (Swearingen, 2016).

Medical Treatments: Administer medications as ordered, such as Oxytocin (Pitocin), Methylergonovine maleate (Methergine), Prostaglandin F2a (Prostin 15M). Increases contractility of the boggy uterus and myometrium, closes off exposed venous sinuses, and stops hemorrhage in the presence of uterine atony (Swearingen, 2016).

Nursing Diagnosis (15 points)

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)** Include a short rationale as to why you chose this intervention & cite the reference appropriately	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Educate the patient on the acute pain related to inflammation associated with increased lupus exacerbations as evidence by	I chose this diagnosis because the patient was diagnosed with having lupus after delivery of her first	**1.** Encourage the client to perform range-of-motion (ROM) exercises after the shower or bath, two repetitions per joint. These exercises	The patient will be able to report pain or stiffness at a level less than 3 to 4 on a scale of 0 to 10.

facial grimace.	child.	help reduce stiffness and maintain joint mobility (Swearingen, 2016). **2.** Remind the client to allow sufficient time for all activities. Performing even simple activities, such as breastfeeding, in the presence of significant joint stiffness can take longer (Swearingen, 2016).	
2. Educate patient of the risk of disturbed body image related to pregnancy as evidenced by striae and C-section.	I chose this diagnosis because the patient will have have lifelong stretch marks and surgical scar.	**1.** Assess the perceived impact of change in ADLs, social participation, personal relationships, and occupational activities. Alteration in body image can have an effect on the patient's ability to carry out daily roles and responsibilities like caring for her newborn baby. (Swearingen, 2016). **2.** Assess the result of body image disturbance in relation to the patient's developmental stage. Young adults may be individually affected by changes in the structure or function of their bodies at a time when	The patient will verbalizes acceptance of self in situation and role as a young mother.

		developmental changes are normally rapid and at a time when developing social and intimate relationships is particularly important (Swearingen, 2016).	

Other References (APA):

Swearingen, P. A. (2016). *ALL-in-ONE: Nursing Care Planning Resource*. St. Louis, MO: Elsevier

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%		