N432 Labor and Delivery Care Plan

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	**Patient Initials**	**Age**	**Gender**
10/30/19 0800	B.N.S	4/1/1991 28 y.o	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Part Time Nurse at Cristie Clinic	Married	Pollen Extracts, NKDA
Code Status	**Height**	**Weight**	**Father of Baby involved**
Full Code	63 inches	177.6 lb	Yes

Medical History (5 Points)

Prenatal History:

GBS positive, G2 P1 T1 P0 A0 L1, 39w6d, one vaginal birth (2017), last menses 1/24/2019

Past Medical History:

Vaginal delivery hx (2017), migraines, childhood asthma, abnormal pap hx, kidney stones

Past Surgical History:

Wisdom tooth extraction

Family History:

No reported family history of hypertension, diabetes, genetic abnormalities, hemorrhage or clotting factor deficiencies

Social History (tobacco/alcohol/drugs):

Alcohol- yes, but not currently

Tobacco- denies use

Drugs- denies use

Living Situation: At home with husband and two-and-a-half-year-old son

Education Level: Bachelor's degree

Admission Assessment (12 points)

Chief Complaint (2 points): Scheduled induction of labor

Presentation to Labor & Delivery (10 points):

G-2, P-1, T-1, P-0, A-0, L-1. Patient's due date was 10/31/19 and was 39 weeks and 6 days gestation. Patient came to OSF for a social induction of labor. Patient experiencing uterine contractions that were 7 minutes apart the night before admission. Patient denying loss of fluids or bleeding and confirms good fetal movement. Patient requesting an epidural for pain management. Patient's PMH includes history of migraines, childhood asthma, kidney stones, abnormal pap smear and one previous vaginal birth in 2017. Patient currently taking prenatal vitamins and the occasional acetaminophen for headaches. Patient's PSH is wisdom tooth extraction. Patient does not report any notable family history. Patient also denies current alcohol use, any drug or tobacco consumption. There was fetal movement noted. She was positive for GBS when swabbed. Patient planned for Foley bulb induction, however, was 3 centimeters dilated upon arrival. Bloody show present during vaginal examination. Baby in LOA position.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points): Social induction of labor

Secondary Diagnosis (if applicable):.

Stage of Labor (20 points):

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

The first stage of labor is known to be the process of progressive dilation of the cervix (Ricci, 2017). The first stage ends when the cervix is large enough to pass a fetal head through it at around 10 centimeters. The first stage of labor can last up to 12 hours but that varies. There are three different phases involved in the first stage of labor. These phases include the latent/early phase, the active phase and the transition phase. The latent phase can last about nine hours, the active phase six hours and the transition phase about one hour (Ricci, 2017).

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

The first stage of labor is identified through vaginal examination of the cervical dilation and is recorded in centimeters (Ricci, 2017). The first stage can also be identified through the rupture of fetal membranes, otherwise known as the water breaking. The latent phase can be identified by the cervical dilation from 0 to 3 centimeters. The cervix dilates from four to seven centimeters during the active phase and from eight to ten centimeters during the transition phase. This patient arrived to OSF at 0800 on 10/30/19 for a social induction. Upon vaginal examination patient's cervical dilation was at 3 centimeters with bloody show. Patient did not report any rupture of fetal membranes.

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

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

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

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

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.28-5.56	4.20	4.03	4.03	N/A
Hgb	12-17	12.8	12.6	12.6	N/A
Hct	33.2- 45.3	37.2	36.2	36.2	N/A
Platelets	150-400	256	197	197	N/A
WBC	4.5-11	7.0	8.6	8.6	N/A
Neutrophils	45.3- 79.0%	66%	73.9%	73.9%	N/A
Lymphocytes	11.8-45.9%	25%	18.0%	18.0%	N/A
Monocytes	4.4-12.0%	8%	6.4%	6.4%	N/A
Eosinophils	0-6.3	0.1	0.0%	0.0%	N/A
Bands	< 10%	1%	0.1%	0.1%	N/A

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

Lab Test	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal
Blood type	A, B, AB, O	A	A	A	N/A
Rh factor	+/-	+	+	+	N/A
Serology (RPR/ VDRL)	Non reactive	Non reactive	Non reacitve	Non reactive	N/A
Rubella Titer	N/A	Immune	Immune	Immune	N/A
Hct & Hgb	12-17 & 33.2- 45.3	12.8 & 37.2	12.6 & 36.2	12.6 & 36.2	N/A
HIV	Non reactive	Non reactive	Non reactive	Non reactive	N/A
HbSAG	Non detected	Non detected	Non detected	Non detected	N/A
Group Beta Strep Swab	+/-	+	+	+	N/A
Glucose at 28 weeks	70-110	N/A	N/A	N/A	N/A

Genetic testing: if done	N/A	N/A	N/A	N/A	N/A

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

Lab Test	**Normal Range**	**Prenatal Value**	**Admission Value**	**Today's Value**	**Reason for Abnormal**
Color & Clarity	Yellow & clear	Yellow & clear	Yellow & clear	Yellow & clear	N/A
pH	5.0-8.0	N/A	N/A	N/A	N/A
Specific Gravity	1.005-1.035	N/A	N/A	N/A	N/A
Glucose	Normal	Negative	Negative	Negative	N/A
Protein	Negative-normal	Negative	Negative	Negative	N/A
Ketones	Negative	Negative	Negative	Negative	N/A
WBC	<5	N/A	N/A	N/A	N/A
RBC	0-3	Negative	Negative	Negative	N/A
Leukoesterase	Negative	Negative	Negative	Negative	N/A

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

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

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

N/A	N/A	N/A	N/A	N/A	N/A

Lab Correlations Reference (APA):

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

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM Tracing	**Your Assessment**
What is the Baseline (BPM) EFH?	**135** Electronic Fetal Heart Monitoring is the continuous monitoring providing audio and visual recordings as well as tracing strips
Are there accelerations, if so describe them and explain what these mean i.e. how high do they go and how long do they last? **What is the variability?**	Accelerations: > 15 bpm, lasting 15 seconds or more Variability: Moderate Moderate variability indicates that the autonomic and CNS of the fetus are well developed and well oxygenated (Ricci, 2017). Beat to beat ranging from 6 to 25. An acceleration is an abrupt increase in FHR above baseline. The duration of the acceleration is defined as the time from the initial change in heart rate from the baseline to the time of return to the FHR to baseline.
Are there decelerations, if so describe them. **What do these mean?** **Did the nurse perform any interventions with these?** **Did these interventions benefit the patient or fetus?**	Decelerations: Absent/ None Decelerations are the transient fall in FHR caused by stimulation of the parasympathetic nervous system (Ricci, 2017). Decelerations are described by their shape and association to uterine contractions. No nursing interventions were performed for this patient. Late decelerations are associated with uteroplacental insufficiency.

	Variable decelerations are associated with cord compression. Prolonged decelerations are associated with prolonged cord compression, abruptio placenta, cord prolapse supine positioning or uterine rupture.
Describe the contractions i.e. frequency, length, strength, patient's response.	Contractions 4-5 minutes apart, lasting 60 to 90 seconds, mild by palpation and the patient is tolerating well, resting tone soft by palpation

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

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

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	Acetaminophen (Tylenol)	Prenatal Multivitamin			
Dose	325mg	1 tablet			
Frequency	PRN	HS			
Route	Oral	Oral			
Classification	Antipyretic, nonopioid analgesic	Multivitamin			
Mechanism of Action	Blocks prostaglandin production and interfering with pain impulse generation in peripheral nervous system	Treat vitamin deficiencies caused by dietary insufficiency			

Reason Client Taking	Mild/severe pain	Overall health			
Contraindications (2)	-severe hepatic impairment -severe active liver disease	-hypersensitivity -alcoholism			
Side Effects/Adverse Reactions (2)	-hypoglycemic coma -hepatotoxicity	-constipation -diarrhea			
Nursing Considerations (2)	-caution in patients with hepatic impairment - caution in alcoholic patients	-monitor patient with hx of alcoholism -monitor for stomach/ intestinal			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver function test results (AST, ALT, bilirubin and creatinine)	Monitor hemoglobin			
Client Teaching needs (2)	-tablets may be crushed or swallowed -follow dosage guidelines	-take on empty stomach -avoid antacids and dairy products			

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Ondansetron (Zofran)	Oxytocin (Pitocin)	Methylergonovine (Methergin)	Fentanyl	
Dose	975mg	4mg	30 units/ 500mL	200 mcg	50 mcg	
Frequency	Q6H	Q6H	1-2 mU/min every 30-60 minutes	Every 2 hours, PRN	Every 2 hours, PRN	
Route	Oral	Oral	Intravenous	Intramuscular	SQ Injection	
Classification	Antipyretic,	Antiemetic	Parenteral	Ergot Alkaloids	Opioid	

	nonopioid analgesic		hormone			
Mechanism of Action	Blocks prostaglandin production and interfering with pain impulse generation in peripheral nervous system	Blocks serotonin receptors at vagal nerve terminals in the intestine	Synthetic oxytocin that initiates uterine contractions	Improves smooth muscle tone of the uterus, helps delivery the placenta and control bleeding	Binds to opioid receptor sites altering perception of and emotional response to pain	
Reason Client Taking	Mild/severe pain	Nausea	Induction of labor	Bleeding	Severe pain	
Contraindications (2)	-severe hepatic impairment -severe active liver disease	-congenital long QT syndrome -hypersensitivity	-hepatic impairment -anticipated nonvaginal delivery	-hypersensitivity -do not use if pregnant	-severe bronchial asthma -hypersensitivity	
Side Effects/Adverse Reactions (2)	-hypoglycemic coma -hepatotoxicity	-altered taste -abdominal pain	-uterine rupture -water intoxication	-nausea -stomach pain	-blurred vision -agitation	
Nursing Considerations (2)	-caution in patients with hepatic impairment - caution in alcoholic patients	-monitor EKG -correct electrolyte imbalances before administering	-monitor for signs of water intoxication -assess characteristics, frequency, and duration of contractions	-do not use if toxemia of pregnancy -do not administer if baby not born yet	-do not give during pregnancy or labor -do not give if mother is breastfeeding	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver function test results (AST, ALT, bilirubin and creatinine)	Monitor for hypokalemia or hypo magnesium	Monitor blood pressure and FHR	Monitor blood pressure	Monitor respiratory rate	
Client Teaching needs (2)	-tablets may be crushed or swallowed -follow dosage guidelines	-use calibrated container to measure -transient blindness will	-advise patient to expect contractions similar to menstrual	-avoid grapefruit/ grapefruit juice -keep out of reach of children	-do not take more than prescribed -avoid alcohol and other CNS	

		resolve within a few minutes to 48 hours	cramps -expect severity and frequency of contractions to increase		depressants	

Medications Reference (APA): (2 points)

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

Methergine (oral and injection) Uses, Side Effects & Warnings. (n.d.). Retrieved from https://www.drugs.com/mtm/methergine-oral-and-injection.html.

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A&O x 4 Patient does not appear distressed Patient's overall appearance appropriate for post partum
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	**Braden Score: 23 (low risk)** Patient states she is Caucasian and presents with a fair skin tone. Skin has normal elasticity warm to touch. No abnormal texture. Hair is dispersed well throughout. No notable skin turgor. No rashes or bruises. No drains present.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:**	Head is midline with no deviations. Patient reported having a minor headache, states occurrence every morning. Hair is blonde in color. Ears show no abnormal drainage, tympanic

Nose: **Teeth:**	membrane visible, pearly grey. PEERLA is noted. Nose shows no deviated septum, turbinates equal bilaterally. Oral mucosa is pink and moist with no notable abnormalities. Patient's teeth present in yellow to white in color.
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:**	Patient is not currently being monitored by telemetry. Patient was noted to be in normal sinus rhythm on admission and this morning upon assessment. S1, S2 heart sounds noted. Radial and pedal pulses assessed. Pulses graded 2+ and present bilaterally. Capillary refill average at < 3 seconds. Negative for neck vein distention. No edema present
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No accessory muscle use when breathing. Trachea midline. No deviations. Patient is denies current shortness of breath. Anterior and posterior lung sounds auscultated. Patient currently breathing room air.
GASTROINTESTINAL (5 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:**	Patient states at home her diet is regular. Bowel sounds present in all four quadrants. Last BM 10/28 No scars noted. No masses present. No ostomy, nasogastric tubes, PEG tubes. No drains. Abdomen is soft and nondistended. Patient denies any rapid or current weight loss.

Incisions: **Scars:** **Drains:** **Wounds:** **Fundal Height & Position:**	
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 able to ambulate in her room and to the bathroom independently. No dialysis or catheter. Urine is yellow and clear Patient denies pain, hesitancy or urgency on urination. No abnormal odor or color Patient is on I&O's.
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	**Fall Score: 20 (low risk)** Patient exhibits active range of motion bilaterally. Patient shows no sign of neurovascular deficit. Patient up and walking independently. Patient denies use of walker, cane, or wheel chair at home. Patient denies the use of any other assistive devices around her home.
NEUROLOGICAL (1 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐**	Patient appears fatigued, going in and out of sleep throughout shift A& O x4. Patient speaks English well and at a

Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	normal pace. Patient MAEW for current age and condition. Patient shows no signs of neurological deficit or damage
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 denies current alcohol, drug or tobacco use. Patient appears to have good family support. Patient is Lutheran Patient is currently working part time at Christie clinic. Patient lives at home with husband and two-and-a-half-year-old son .
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	N/A

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	98	117/73	18	98.1	97
Labor/Delivery	86	113/58	18	98.1	98

Labor/Delivery	81	90/53	18	98.2	95

Vital Sign Trends:

Vital signs slightly decreased through the stage of labor. However, vitals appear to be consistent. Patient blood pressure hypotensive during prenatal reports and during labor.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0908	Numeric	IV arm site	3/10	Pain in arm	Ice wrap given to alleviate pain
1000	Numeric	Abdominal pain/ contractions	4/10	Cramping	Repositioning, more pillows given for comfort

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	Right hand (lateral side)
Location of IV:	18g peripheral IV
Date on IV:	Dated 10/30/19
Patency of IV: **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Blood return, able to obtain, flushed w/o difficulty, infusing, site cleansed and secured, no phlebitis or infiltration IV dressing clean, dry and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
500 mL (IV)	N/A

Interventions (12 points)

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Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

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

Patient taught using handouts

Patient acceptance, teach back and verbalizes understanding

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

Patient taught using handouts and using the teach back method

Patient acceptance, teach back and verbalizes understanding

Nursing Interventions (6 points)

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

Nursing Interventions: Introduction of Pitocin to patient via intravenous flow

Rational: Patient receiving a social induction of labor, requiring Pitocin to further the severity, frequency and duration of contractions in attempt to further along the labor process.

Medical Treatments: Pitocin given intravenously. Pitocin rate increased every 30 minutes until contractions measuring every 2-3 minutes apart

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as	• Explain why the nursing diagnosis was	Include a short rationale as to why	• How did the client/family respond to the nurse's actions?

evidenced by" components	chosen	you chose this intervention & cite the reference appropriately	• Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to uterine cramping and backache as evidenced by patient's increasing contractions	**Patient reporting increase in severity and duration of contractions as Pitocin increased**	**1. Evaluate patient's level of pain/ cramping using a scale of 0-10. A baseline assessment will enable proper analgesia and help determine relief of pain obtained after subsequent evaluation** **2. Provide emotional support to aid in decreasing anxiety which also may decrease the level of pain**	**Patient responding well to evaluation of pain. Patient does not report uterine pain greater than 5/10. Patient responds well to emotional support from nursing staff as well as family reporting a decrease in her worries**
2. Impaired skin integrity related to wound infection or dehiscence as evidenced by induction of vaginal delivery	**Patient scheduled for induction of a vaginal delivery potentially resulting in perineum tearing**	**1. Assess patient and significant other's level of acceptance/ confidence in caring for the wound on an outpatient basis. Patient teaching and reassurance will provide opportunity for patient to take control of own care.** **2. Teach patient and significant other aseptic techniques in caring for the wound. These measures decrease the risk of introducing additional microorganisms into**	**Patient aware of the potential after care required with vaginal delivery. Patient and significant other confident in ability to maintain a clean wound site. Patient and significant other have experience due to previous vaginal delivery in 2017**

		the wound	

Other References (APA):

Swearingen, P. L. (2016). All-In-One Nursing Care Planning Resource (4 ed.). St. Louis, Missouri: 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) **Living situation** **Education level** • If applicable to learning	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	

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 **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	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	

	correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.		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 written in correct APA format.	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.	All key components have been addressed and the student shows an understanding of the norms and abnormalities.	One or more of the key components is missing, yet the student is able to demonstrate an understanding of the diagnostic testing and is	Student did not have an understanding of EFHM and the abnormalities. Student did not have an APA reference listed.	

• Interventions performed • Normal values/expected values are listed • Minimum of 1 APA reference, no reference will result in zero points for this section	Student had 1 reference listed and is able to correlate abnormal findings to the client's particular disease process.	able to correlate the abnormal findings to the disease process.		

Current Medications	10 points	1-9 points	0 points	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
	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.	

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					
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*	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	

• Student highlighted the abnormal vital signs • Student wrote a summary of the vital sign trends				
Pain Assessment	**2 points**	**1 point**	**0 points**	**Points**
Pain assessment • Pain assessment was addressed and recorded twice throughout the care of this client • It was recorded appropriately and stated what pain scale was used	All the key components were met (2 pain assessments) for this section and student has a good understanding of the pain assessment.	One assessment is incomplete.	Student did not complete this section	

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

• 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
	components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	the nursing diagnosis/rational/intervention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.	

Overall APA format	**5 Points**	**1-4 Points**	**0 Points**	**Points**
APA Format • The student used appropriate APA in text citations and listed all appropriate references in APA format. • Professional writing style and grammar was used in all narrative sections.	APA format was completed and appropriate. Grammar was professional and without errors	APA format was used but not correct. Several grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	

		Points
- Instructor Comments:	**Total points awarded**	
Description of Expectations	**/150= %**	

Must achieve 116 pt =77%	