N432 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 **10/22/2019 12:31 PM**	**Patient Initials** **RK**	**Age** **27**	**Gender** **F**
Race/Ethnicity **White/Caucasian**	**Occupation** **works in marketing**	**Marital Status** **Married**	**Allergies** **NKDA**
Code Status **Full**	**Height** **5'7"**	**Weight** **184 lbs**	**Father of Baby involved** **yes**

Medical History (5 Points)

Prenatal History: Prenatal care started on 03/11/2019.

Past Medical History: No significant past medical history**.**

Past Surgical History: Wisdom tooth extraction**.**

Family History: no pertinent family history on file**.**

Social History (tobacco/alcohol/drugs): She reports that she has never smoked. She has never used smokeless tobacco.

She reports that she drank alcohol. She reports that she does not use drugs

Living Situation: Living currently with husband and 1 child.

Education Level: Patient has a Bachelor's degree.

Admission Assessment (12 points)

Chief Complaint (2 points):

Presentation to Labor & Delivery (10 points):. Patient is a 27 year old G3P1011 female with IUP at 39w6d with 10/23/2019, by last menstrual period consistent with a 12 week ultrasound came to the hospital for an elective induction of labor. She came from an office visit because of a non-reactive non-stress test and elevated blood pressures. Her blood pressures once admitted have been within normal limits and her preeclampsia labs were normal. Her baby had minimal variability when she came in which improved once IV fluids were administered. She was offered and accepted induction of labor due to cervix presentation. Her pregnancy has been without other complications. Her blood type is O negative and she was given Rhogam on 8/8/19.

Diagnosis (2 points)

Primary Diagnosis on Admission (2 points):.Non reactive NST and elevated BP

Secondary Diagnosis (if applicable):.induction of labor

Stage of Labor (20 points):

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

Puerperium

Puerperium is the stage of labor that lasts from delivery until about 6 weeks postpartum, although it is thought by some that this period lasts until the end of the first year after the child is born. During this time the postpartum mother's body undergoes a multitude of changes as it returns to its pre-pregnancy state. These changes include not only the physical changes that are occurring in the body but also the adjustment of the new mother to motherhood (Ricci, Kyle & Carman, 2017). The mother that I was caring for was day one postpartum.

At day one after birth, the uterus has already begun the transition from pregnancy to postpartum state. Contraction of the uterus and destruction and remodeling occur immediately after the placenta is delivery, this is referred to as involution. Lochia, or vaginal discharge, is a result of this involution and can continue for 4-8 weeks postpartum (Ricci, Kyle & Carman, 2017). This patient was having blood tinged lochia, which is to be expected on the first day after birth. After delivery, the normal amount of lochia can be from 8-9 oz or roughly

approximate to that experienced during a heavy menstrual cycle. This stage of lochia is called lochia rubia and will continue for 3-4 days postpartum (Ricci, Kyle, & Carman, 2017).

The cervix also undergoes changes as it returns to its pre-pregnancy state, it will close but never has the same appearance after pregnancy. The vagina on day one is edematous with rugae and will have restored epithelium by 6-8 weeks, but generally will remain larger after pregnancy that it was in its pre-pregnancy state. If an episiotomy was performed, the perineum may be swollen and bruised and can take up to 4-6 weeks to heal (Greenberg, no date). This patient had an episiotomy which required sutures. This patient is expected to heal well from episiotomy and have a relatively quick recovery.

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

Greenberg, E. (no date). The fourth stage of labor. Retrieved from https://www.ajog.org/article/0002-9378(46)90181-0/pdf

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

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.8-5.3**	**4.36**	**4.46**	**NA**	
Hgb	**12-15.8**	**13.8**	**14.8**	**NA**	
Hct	**36.0-47.0**	**38.4**	**41.6**	**NA**	
Platelets	**140-440**	**239**	**239**	**NA**	
WBC	**4.0-12.0**	**8.2**	**12.8**	**NA**	**Elevated WBC levels in pregnancy can mean the body is properly responding to elevated demand of erythropoiesis (Ricci, Kyle & Carman, 2017).**
Neutrophils	**47.0-73.0**	**69**	**83.5**	**NA**	**Elevated Neutrophil levels in pregnancy can mean the body is**

					properly responding to demands of pregnancy (Ricci, Kyle & Carman, 2017).
Lymphocytes	**18.0-42.0**	**23**	**11.5**	**NA**	**Elevated Lymphocytes levels in pregnancy can mean the body is properly responding to demands of pregnancy (Ricci, Kyle & Carman, 2017).**
Monocytes	**4.0-12.0**	**7**	**4.2**	**NA**	
Eosinophils	**0.0-5.0**	**0**	**0.1**	**NA**	
Bands	**NA**	**NA**	**NA**	**NA**	

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	**O, A, or AB**	**O**	**O**	**O**	
Rh factor	**negative or positive**	**negative**	**negative**	**negative**	
Serology (RPR/VDRL)	**NR**	**NR**	**NR**	**NR**	
Rubella Titer	**immune**	**immune**	**immune**	**immune**	
Hct & Hgb	**HGB-11.7-16.0** **HCT 35.0-47.0**	**HGB-13.8** **HCT 38.4**	**NA**	**NA**	
HIV	**non-detected**	**non-detected**	**NA**	**NA**	
HbSAG	**NR**	**NR**	**NR**	**NR**	
Group Beta Strep Swab	**negative**	**negative**	**negative**	**negative**	
Glucose at 28	**pass or fail**	**pass**	**na**	**na**	

weeks					
Genetic testing: if done	**na**	**na**	**na**	**na**	

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	**clear/yellow**	**clear/yellow**	**na**	**na**	
pH	**5-8**	**6.0**	**NA**	**NA**	
Specific Gravity	**1.010 to 1.030**	**1.020**	**na**	**na**	
Glucose	**negative**	**negative**	**na**	**na**	
Protein	**negative**	**negative**	**na**	**na**	
Ketones	**negative**	**na**	**na**	**na**	
WBC	**negative**	**na**	**na**	**na**	
RBC	**negative**	**na**	**na**	**na**	
Leukoesterase	**negative**	**na**	**na**	**na**	

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	**negative**	**negative**	**na**	**na**	

Other Tests	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal

NA	**NA**	**NA**	**NA**	**NA**	

Lab Correlations Reference (APA):

Laboratory Values: NCLEX-RN (2019). Retrieved from

https://www.registerednursing.org/nclex/laboratory-values/

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

Electronic Fetal Heart Monitoring (20 points)

Component of EFHM **Tracing**	**Your Assessment**
What is the Baseline (BPM) EFH?	**140**
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?**	**yes, greater than 15 seconds, lasting at least 15 seconds**
Are there decelerations, if so describe them. **What do these mean?**	**absent** **no decelerations**

Did the nurse perform any interventions with these? **Did these interventions benefit the patient or fetus?**	**na** **na**
Describe the contractions i.e. frequency, length, strength, patient's response.	**3-4 minutes apart** **60-90 second length** **strong intensity** **patient tolerated contractions**

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

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

Home Medications (2 required)

Brand/Generic	**prenatal vitamins**	**Tylenol/Acetaminophen**			
Dose	**1 tab**	**500 mg**			
Frequency	**QD**	**prn**			
Route	**PO**	**PO**			
Classification	**vitamin**	**■Analgesic**			

		■Antipyretic			
Mechanism of Action	**Folic acid is a B vitamin that cells in your body need for growing and developing**	**■Acetaminophen is a centrally acting analgesic and antipyretic with minimal anti-inflammatory properties. The mechanism of action of acetaminophen in reducing pain is unknown but may be due to an inhibition of central prostaglandin synthesis (specifically cyclooxygenase (COX)-2) and an elevation of the pain threshold. Acetaminophen reduces fever by inhibiting the formulation and release of prostaglandins in the CNS and by inhibition endogenous pyrogens at the**			

		hypothalamic thermoregulatory center			
Reason Client Taking	**pregnancy**	**pain management**			
Contraindications (2)	**hypersensitivity** **iron metabolism disorder causing increased iron storage**	**■Active and severe hepatic disease [8]** **■Hypersensitivity to acetaminophen or any other components of the product [8]** **■Severe hepatic impairment [8]**			
Side Effects/Adverse Reactions (2)	**constipation** **dark stools**	**pruritus** **constipation**			
Nursing Considerations (2)	**consider giving stool softeners** **do not give with milk**				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**monitor for toxicity** **monitor kidney function**	**liver function** **ALT/AST**			

Client Teaching needs (2)	**Do not take with milk** **Take with vitamin C if possible**	**■Advise patient it is unsafe to take more than 4000 mg of acetaminophen in a 24-hour period [4]. For Tylenol(R) Extra Strength, the maximum dose is 3000 mg in 24 hours [3].** **■Instruct patient that many non-prescription combination products may contain acetaminophen.**			

Medications Reference (APA): (2 points)

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (18th ed.). Burlington, MA: Jones & Bartlett Learning.

Hospital Medications (5 required)

Brand/Generic	**oxytocin/pitocin**	**hydrocortisone/Anusol HC**	**Misoprostol/ cytotec**	**colace/docusate sodium**	**Zofran/ondansetron**
Dose	**1-20 milliunits per**	**1%**	**1000 mcg**	**100 mg**	**4 mg**

	minute				
Frequency	**continuous**	**prn**	**once prn**	**BID, prn**	**prn**
Route	**IV**	**topical**	**rectal suppository**	**PO**	**IV**
Classification	**pitocin**	**■Adrenal Glucocorticoid** **■Anti-Inflammatory** **■Corticosteroid, Weak** **■Endocrine-Metabolic Agent** **■Gastrointestinal Agent** **■Otic Agent**	**■Endocrine-Metabolic Agent** **■Prostaglandin**	**■Laxative, Stool Softener**	**■Antiemetic** **■Serotonin Receptor Antagonist, 5-HT3**
Mechanism of Action	**•Oxytocin promotes uterine contractions by increasing the intracellular concentrations of calcium in uterine myometrial tissue, thereby increasing the activity of the calcium-dependent phosphorylating enzyme myosin**	**■Hydrocortisone, a naturally occurring glucocorticoid (adrenal corticosteroid) acts as an anti-inflammatory, antipruritic, and vasoconstrictive agent, and has salt-retaining properties. It is also used as replacement therapy in**	**Misoprostol enhances natural gastric mucosal defense mechanisms and healing in acid-related disorders, probably by increasing production of gastric mucus and mucosal secretion of bicarbonate**	**works by actively drawing water into the stool, thus softening the stool and achieving ease in bowel movement**	**■Ondansetron is a selective 5-hydroxytryptamine-3 (5-HT3)-receptor antagonist used for the prevention of chemotherapy-induced nausea and vomiting. Ondansetron may work by**

	light-chain kinase. The effect is greatest during early labor at term due to the oxytocin receptor concentration which increases during pregnancy and peaks at term. Oxytocin also has pressor and antidiuretic activity which may be exhibited with high doses	**states of adrenocortical deficiency**			**blocking 5-HT3 receptors peripherally on vagal nerve terminals and centrally in the chemoreceptor trigger zone**
Reason Client Taking	**induction of labor**	**hemorrhoids**	**postpartum hemorrhage**	**constipation**	**nausea**
Contraindications (2)	**•Significant cephalopelvic disproportion** **•Unfavorable fetal positions or presentations (eg, transverse lies), which are undeliverable without conversion prior to delivery**	**■Hypersensitivity to hydrocortisone or any of its components[8]** **■Systemic fungal infections with use of oral tablets or rectal suspension**	**■Pregnant women, for reducing the risk of NSAID-induced ulcers; birth defects, abortion, or premature birth may occur [6]** **■Hypersensitivity to prostaglandins**	**■hypersensitivity to docusate products** **■concomitant use of mineral oil**	**■Concomitant use of apomorphine** **■Hypersensitivity to ondansetron or any component of the product**

Side Effects/Adverse Reactions (2)	**pelvic hematoma** **Afibrinogenemia**	**Osteoporosis** **Psychotic disorder**	**abdominal pain** **diarrhea**	**Diarrhea, Nausea**	**constipation** **diarrhea**
Nursing Considerations (2)	**monitor amplitude** **monitor frequency of contractions**	**■improvement of clinical symptoms** **■blood pressure; large doses therapy**	**■uterine activity and fetal status when used for cervical ripening** **■patients with underlying conditions such as inflammatory bowel disease, or those in whom dehydration would be dangerous if it were to occur**	**assess for rectal bleeding** **reassess if no bowel movement after laxative**	**■ECG; in patients with electrolyte abnormalities (eg, hypokalemia, hypomagnesemia), congestive heart failure, bradyarrhythmias, or with concomitant use of QT-prolonging medications** **■Signs and symptoms of serotonin syndrome; particularly when used concomitantly with drugs that affect**

					serotonin
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**monitor fetal heart rate** **monitor uterine activity**	**■ACTH stimulation test; periodic in large doses and long-term therapy**	**■The last dose of the day should be taken at bedtime**	**check for bowel movement**	**■Reduction in nausea and vomiting is indicative of clinical efficacy**
Client Teaching needs (2)	**-Medicines used to induce labor may cause too many contractions. -This can lower your baby's heartbeat and decrease his or her oxygen supply. -Induction of labor also increases the risk of umbilical cord prolapse.**	**■Advise patient to avoid vaccines during oral therapy unless approved by healthcare professional.** **■This drug may cause impaired skin healing, decreased body growth, depression, or euphoria**	**■Recommend female patient avoid pregnancy during therapy and for at least 1 month after discontinuation .** **■Side effects may include abdominal pain, diarrhea, dyspepsia, flatulence, nausea, vomiting, or headache**	**■Tell patient not to take drug if experiencing acute abdominal pain, nausea, vomiting, or sudden change of bowel habits of over 2 week duration.** **■Advise patient that stool softeners usually work within 1 to 2 days. Results may take as long as 3 to 5 days. Patient should report if no bowel movement occurs after using laxative.**	**■Warn patient to report symptoms of QT prolongation** **■Instruct patient to report symptoms of progressive ileus, gastric distension, or bowel obstruction**

Medications Reference (APA): (2 points)

Assessment (20 points)

Physical Exam (20 points)

GENERAL (0.5 point): **Alertness:** alert **Orientation:** oriented x4 **Distress:** no apparent distress **Overall appearance:** calm and cooperative	**(all the answers are in the box on the other side, didn't skip it just answered in the other box)**
INTEGUMENTARY (2 points): **Skin color:** pink **Character:** dry **Temperature:** warm **Turgor:** good turgor **Rashes:** no rashes **Bruises:** no bruises **Wounds/Incision:** perineal incision **Braden Score:** 24 **Drains present: Y☐ N x** **Type:na**	
HEENT (0.5 point): **Head/Neck:** Normocephalic, trachea midline **Ears:** pearly grey TM **Eyes:** conjunctiva and sclera clear, no exudate **Nose:** midline, moist turbinates, no polyps **Teeth:** good dentition	.
CARDIOVASCULAR (1 points): **Heart sounds:** Clear S1 and S2 without	.

murmurs or gallops **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):**normal rate and rhythm **Peripheral Pulses:**2+ **Capillary refill:** <3 seconds **Neck Vein Distention: Y ☐ N x** **Edema Y x N ☐** **Location of Edema:** bilateral feet and ankles	
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N x** **Breath Sounds: Location, character:** clear to auscultation bilaterally, no increased work of breathing	
GASTROINTESTINAL (5 points): **Diet at home:** regular **Current Diet** regular **Height:** 5'7" **Weight:**184 **Auscultation Bowel sounds:** normoactive **Last BM:** 10/23/2019 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** none **Incisions:**none **Scars:**none **Drains:** none **Wounds:**Episiotomy	.

Fundal Height & Position: Midline just below umbilicus	
GENITOURINARY (5 Points): **Bleeding:** Lochia present **Color:** bright red **Character:** no clots present **Quantity of urine:** 650 mL **Pain with urination: Y ☐ N x** **Inspection of genitals:** **Catheter: Y ☐ N x** **Type: na** **Size: na** **Rupture of Membranes: AROM** **Time: 10/22/2019 2145** **Color: clear** **Amount: small** **Odor:none** **Episiotomy/lacerations: right mediolateral**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N x** **Fall Risk: Y ☐ Nx** **Fall Score: 0** **Activity/Mobility Status: Full mobility** **Independent (up ad lib) x** **Needs assistance with equipment ☐ no** **Needs support to stand and walk☐ no**	

NEUROLOGICAL (1 points): **MAEW: Y x N☐** **PERLA: Y x N☐** **Strength Equal: Y x N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** oriented x4 **Mental Status:** alert **Speech:** intact **Sensory:**intact **LOC:**awake, alert and oriented x4 **DTRs:** 2+	.
PSYCHOSOCIAL/CULTURAL (1 points): **Coping method(s):** Talk therapy **Developmental level:** high functioning **Religion & what it means to pt.:** Protestant and patient reports her religious belief helped her through labor **Personal/Family Data (Think about home environment, family structure, and available family support):** Very supportive husband and family system. Parents of both the mother and father involved and helping support the couple.	.
DELIVERY INFO: (1 point) (For Postpartum client) **Delivery Date:** 10/22/2019 **Time:** 1235 **Type (vaginal/cesarean):** induced vaginal **Quantitative Blood Loss:** 427 mL	

Male or Female: male **Apgars:**8 and 9 **Weight:**3935 g **Feeding Method:**breastfeeding	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal 10/22/2019 at 1231	**88**	**125/85**	**16**	**97.0**	**100 on room air**
Labor/Delivery 10/23/2019 at 1235	**100**	**127/85**	**20**	**98.0**	**100 on room air**
Postpartum 10/23/2019 @ 0700	**78**	**121/78**	**16**	**98.4**	**99 on room air**

Vital Sign Trends: This patient's blood pressure, respiratory rate and pulse rate are trending down. This makes sense due to the intensity of labor pain having an increasing effect on vitals during labor. There were no significant changes in the temperature or oxygen saturation.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**0-10**	**perineum**	**2**	**soreness**	**none**

1000	**0-10**	**perineum**	**2**	**soreness**	**none**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** metacarpal vein (top of hand), right **Date on IV:** 10/22/2019 **Patency of IV:** patent **Signs of erythema, drainage, etc.:** no erythema, no drainage **IV dressing assessment:** dry and intact	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
115.0 mL	**650 mL**

Interventions (12 points)

Teaching Topics (6 points)

Include how you would teach the information & an expected outcome

1. Education on how often feeding should occur is important for a new mother. I would teach using discussion as well as question and answer with the patient. I would expect her to understand the feedings should occur every 2-3 hours.
2. As my patient was having difficulty with breastfeeding, I would also teach the use of a nipple shield. I would use illustration methods for this type of teaching and help the mother to understand that the child needs to suck to pull the nipple into the shield. This gives the infant a more sturdy grasp and also protects the nipple of the mother.

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Nursing Interventions (6 points)

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

Nursing Interventions: Assessed breasts for any cracks or fissures. Also, assessed for signs of mastitis such as inflammation of a certain part of the breast. Assessed the location, consistency, and height of the fundus through palpation. Informed patient that if the uterus is not firm upon palpation, to massage it gently. Placed the infant on the mother's breast to aids in stimulating contractions. Informed patient that Lochia is expected in a postpartum woman for 2 to 6 weeks, so assessing its characteristics is necessary to determine if it is the normal lochia or not. Observed the perineum for ecchymosis, hematoma, edema or any drainage and bleeding from the stitches.

Medical Treatments: We administered pain medication to the mother as well as other uterine contraction medications. Massaged the fundus of the patient. Inspected, and assisted with perineal and suture care from the episiotomy.

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. Risk for infection related to presence of broken skin and or traumatized tissue as evidenced by episiotomy	Allows early identification and treatment; promotes resolution of infection.Progression to necrotizing fasciitis can be life-threatening.	**1.** Observe perineum/incision for other signs of infection such as redness, edema, ecchymosis, discharge and approximation Rationale: Early	**Outcome: Met. The patient was able to recite back to me signs of infection such as redness, swelling, streaking, warmth and drainage. Patient was also able to demonstrate proper perineal care. The mother**

		identification of infection. **2.** Demonstrate correct perineal cleaning after voiding and defecation, and frequent changing of peripads**.** Rationale: Cleaning removes urinary/fecal contaminants. Changing pad removes moist medium that favors bacterial growth	**and family were responsive and attentive to teaching. No modifications needed.**
2. Acute pain related to vaginal birth as evidenced by patient pain rating of 2	Unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage; sudden or slow onset of any intensity from mild to severe with an anticipated or predictable end and a duration of 6 months	**1.** Assess location and nature of discomfort or pain, rate pain on a 0–10 scale Rationale: Helps in the differential diagnosis of tissue involvement in the infectious process **2.** Instruct client in relaxation techniques; provide diversionary activities such as radio, television, or reading Rationale: Refocuses client's attention, promotes positive attitude, and enhances comfort	**Outcome: Patient was able to report a decreased level of pain down to an acceptable level. Patient demonstrated proper pain management and was receptive to the teaching provided.**

Other References (APA):

Nurseslabs. (2019). Puerperal Infections. Retrieved from https://nurseslabs.com

N305 Care Plan Grading Rubric: Labor Student Name:

Demographics	3 points	1.5 points	0 points	
Demographics ● Date of admission ● Patient initials ● Age ● Gender ● Race/Ethnicity ● Occupation ● Marital Status ● Father of baby involvement ● Allergies ● Code Status ● Height ● Weight	Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling.	Two or more of the key components are not filled in correctly.	5 or more of the key components are not filled in correctly and therefore no points were awarded for this section	
Medical History	**5 points**	**2.5 points**	**0 points**	
Prenatal History **Past Medical History** ● All previous medical diagnosis should be listed **Past Surgical History** ● All previous surgeries should be listed **Family History** ● Considering paternal and maternal **Social History** ● Smoking (packs per day, for how may year) ● Alcohol (how much alcohol consumed and for how many years) ● Drugs (how often and drug of choice) **Living situation** **Education level** ● If applicable to learning barriers	Includes each section completed correctly with a detailed list of pertinent medical history, surgical history, family history and social history. If patient is unable to give a detailed history, look in the EMR and chart.	1 or more of the key components is missing detailed information.	More than two of the key components are not filled in correctly	

Admission Assessment -Chief Complaint	2 points	1 point	0 points	Po
Chief complaint ● Identifiable with a couple words of what the patient came in	Chief complaint is correctly identified.	Chief complaint not completely understood.	No chief complaint listed.	

complaining of				
Admission Assessment- History	**10 points**	**6-10 points**	**0-5 points**	**Po**
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**	**Po**
Primary Diagnosis ● The main reason the patient was	All key components are filled in correctly. The student was able to	One of the key components is missing or not understood	Student did not complete this section and there is concern for lack of	

admitted **Secondary Diagnosis** ● If the patient has more than one reason they are being admitted	identify the correct primary diagnosis and listed the appropriate secondary diagnosis if applicable.	correctly.	understanding the diagnosis.	

Stage of Labor	20 points	14-10 points	9-5 points	4-0 p
Stage of Labor ● Professionally written essay in APA format outlined all aspects of the stage of labor the client is in during the student's care ● information is well written and no less than 1 page ● Signs/symptoms of the stage ● Expected findings related to the stage such as vital signs and laboratory findings ● 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	Sect incompl sever factors Student have a unders of the s labor an correlat cli Section in APA with m of 2 ref (0 point giv

Laboratory Data	15 points	5-14 points	4-0 points	
Normal Values ● Should be obtained from the chart when	All key components have been addressed and the student shows an understanding of	1 or more of the client's labs were not reported completely with normal values or	Student did not have an understanding of laboratory values and the abnormalities.	

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	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.	patient results. Lab correlation did not completely demonstrate student's understanding of correlation.	More than 2 labs were excluded. Student did not discuss the abnormal findings in APA format with a minimum of 1 reference.	
Electronic Fetal Heart Monitoring	**20 points**	**19-10 points**	**0-10 points**	
Components of EFHM: ● Baseline ● Accelerations ● Variability ● Decelerations ● Contractions: frequency, duration, intensity ● Correlation of	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	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	Student did not have an understanding of EFHM and the abnormalities. Student did not have an APA reference listed.	

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	the client's particular disease process.	the disease process.		
Current Medications	**10 points**	**1-9 points**	**0 points**	
Current Medications ● Requirements of 5 inpatient hospital medications and 2 home medications—these must be 7 DIFFERENT medications ● Each medication must have brand/generic name ● Dosage, frequency, route given, class of drug and the action of the drug ● Reason client taking ● 2 contraindications must be listed o Must be pertinent to your patient ● 2 side effects or adverse effects ● 2 nursing considerations ● Key nursing assessment(s)/lab(s) prior to	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.	

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				
Physical Assessment	**20 points**	**1-18 points**	**0 points**	
● Completion of a head to toe assessment done on the students own and not copied from the client's chart ● Fall risk assessment ● Braden skin assessment ● **No fall risk or Braden scale will result in a zero for the section**	All key components are met including a complete head to toe assessment, fall risk and Braden score.	One or more of the key components is missing from a given section. Each body system is worth points as listed on care plan	More than half of the key components are missing. Therefore, it is presumed that the student does not have a good understanding of the head to toe assessment process.	

Vital Signs	5 points	2.5 points	0
Vital signs ● 3 sets of vital signs are recorded with the appropriate labels attached ● Includes a prenatal set, labor/delivery set, and postpartum set ● *If client has not delivered for a postpartum set, student is to list TWO vitals from labor and delivery* ● Student highlighted the abnormal vital signs ● Student wrote a summary of the vital sign trends	All the key components were met for this section (with 2 sets of vital signs) and student has a good understanding of abnormal vital signs.	Only one set of vital signs were completely recorded and one of the key components were missing.	Stude comp s
Pain Assessment	**2 points**	**1 point**	**0**
Pain assessment ● Pain assessment was addressed and recorded twice throughout the care of this client ● It was recorded appropriately and stated what pain scale was used	All the key components were met (2 pain assessments) for this section and student has a good understanding of the pain assessment.	One assessment is incomplete.	Stude comp s

IV Assessment	2 points	1 point	0 poin
IV assessment ● IV assessment performed and it is charted including what size of IV and location of the IV ● Noted when the IV was placed ● Noting any signs of erythema or drainage ● Patency is verified and recorded ● Fluid type and rate is recorded or Saline lock is noted. ● IV dressing assessment is recorded (clean, dry and intact)	All of the key components were addressed. Student demonstrates an understanding of an IV assessment.	One of the key components is missing.	More th 1 aspe of the assessm t is missing studer did no comple this sectio

Intake and Output	**2 points**	**1-0 points**	
Intake ● Measured and recorded appropriately—what the patient takes IN ● Includes: oral intake, IV fluid intake, etc. **Output** ● Measured and recorded appropriately—what the client puts OUT ● Includes: urine, stool, drains/tubes, emesis, etc.	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.	One of the key components the intake and output is missing. Difficult to determi if the student has a thorou understanding of the intak and output.	
Nursing Care/Interventions	**12 points**	**2-0 points**	
Nursing Interventions ● List the nursing interventions utilized with your client ● Includes a rationale as to why the intervention is carried out or should be carried out for the client **Teaching topics** ● List 2 priority teaching items ● Includes 1 expected outcome for each teaching topic	All the key components of the summary of care (2 points) and discharge summary (2 points) were addressed. Student demonstrated an understanding of the nursing care.	One or more of the key components of the nursin care was missing, therefore was difficult to determine the student had a thoroug understanding of the nursi care.	
Nursing Diagnosis	**15 points**	**5-14 points**	**4-0 points**
Nursing Diagnosis ● List 2 nursing diagnosis o Include full nursing diagnosis with "related to" and "as evidence d by"	All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.	One or more of the nursing diagnosis/rational/inter vention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.

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				
Overall APA format	**5 Points**	**1-4 Points**	**0 Points**	
APA Format ● The student used appropriate APA in text citations and listed all appropriate references in APA format. ● Professional writing style and grammar was used in all narrative sections.	APA format was completed and appropriate. Grammar was professional and without errors	APA format was used but not correct. Several grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	
			Points	
- Instructor Comments:	**Total points awarded**			
Description of Expectations	**/ 150=**			

	%	
Must achieve 116 pt =77%		