N432 Newborn Care Plan

Lakeview College of Nursing

Teionna Saccocio

Demographics (10 points)

Date & Time of Clinical Assessment:

Date & Time of Birth 6/9/2020 @ 1300	Patient Initials J.S.	Age (in hours at the time of assessment) 55	Gender M
Race/Ethnicity White/Caucasian	Weight at Birth (gm) _____3715_____ (lb.) __8___ (oz.) __3___	Weight at Time of Assessment (gm) _____3435_____ (lb.) __7___ (oz.) __9.2___	Age (in hours) at the Time of Last Weight 48 hrs
Length at Birth Cm ____52_____ Inches ____20.47_____	Head Circumference at Birth Cm ____34_____ Inches _____13.4_____	Chest Circumference at Birth Cm _____34.5_____ Inches ____13.6_____	

There are times when the weight at the time of your assessment will be the same as birth

Mother/Family Medical History (15 Points)

Prenatal History of the Mother:

   When prenatal care started: 11/12/19, 9weeks 2 days

   Abnormal prenatal labs/diagnostics: none

   Prenatal complications: uncomplicated

   Smoking/alcohol/drug use in pregnancy: none

Labor History of Mother:

   Gestation at onset of labor: 39+2

   Length of labor: 16 hrs

ROM: SROM

Medications in labor: epidural (fentanyl-ropivacaine 2-0.2 mcg/mL)

Complications of labor and delivery: none

Family History:

Pertinent to infant: none

Social History (tobacco/alcohol/drugs): Patient denies use.

Pertinent to infant: none

Father/Co-Parent of Baby Involvement: The father is highly involved.

Living Situation: The patient is married and lives with her husband.

Education Level of Parents (If applicable to parents' learning barriers or care of infant):

Both parents are college graduates.

<div align="center">

Birth History (10 points)

</div>

Length of Second Stage of Labor: 2 hrs 20 min

Type of Delivery: SVD

Complications of Birth: loose nuchal cord x1

APGAR Scores:

1 minute: 8

5 minutes: 9

Resuscitation methods beyond the normal needed: none

<div align="center">

Feeding Techniques (10 points)

</div>

Feeding Technique Type: breastfeeding with supplementation

If breastfeeding:

LATCH score: 8

If bottle feeding:

      Positioning of bottle: upright

      Suck strength: strong

      Amount: 15 mL

Percentage of weight loss at time of assessment: __7. 54_____%

      ==Show your calculations==; if today's weight is not available, please show how you

      would calculate weight loss (i.e. show the formula)**

What is normal weight loss for an infant of this age? 10%

Is this neonate's weight loss within normal limits? Yes

<div align="center">

Intake and Output (8 points)

</div>

<u>Intake</u>

If breastfeeding:

      Feeding frequency: every 4 hours/on demand

      Length of feeding session: 30 min

      One or both breasts: both

If bottle feeding:

      Frequency: every 4 hours

      Volume of formula per session: 15 mL

If NG or OG feeding:

      Frequency: N/a

      Volume:N/A

If IV:

      Rate of flow: N/A

Volume in 24 hours: N/A

<u>**Output**</u>

Age (in hours) of first void: 10 hrs

Voiding patterns:

Number of times in 24 hours:4

Age (in hours) of first stool: 10 hrs

Stool patterns: 3 today

Type: meconium

Color: black

Consistency: sticky

Number of times in 24 hours: 3

Laboratory Data and Diagnostic Tests (15 points)

<mark>**Highlight All Abnormal Labs**</mark>—**Explanations must be in complete sentences and contain in-text citations in APA format.**

Name of Test	Why was this test ordered for THIS client? *Complete this even if these labs have not been completed*	Expected Results	Client's Results	Interpretation of Results
Blood Glucose Levels	Infant had a high bilirubin level	45-72	48	Blood glucose is within normal range.
Blood Type and Rh Factor	Routine blood work	Varies	AB+	Infant is Rh positive

Coombs Test	This test would be indicated if mother is Rh negative	negative	NA	This test was not performed
Bilirubin Level (All babies at 24 hours) *Utilize bilitool.org for bilirubin levels*	Routine blood work for newborn screening	< 7	13.2	Infant's bilirubin level is elevated.
Newborn Screen ←Ths is the newborn metabolic screen. The PKU is one of the disorders screened for. (At 24 hours)	Routine for newborn screening,	➢ 94%	Sp02- preductal 99%, postductal 100% Critical congenital heart defect- negative, pass ←This belongs under the Newborn Cardiac screen.	Infant's SP02 levels are within normal range.
Newborn Hearing Screen	Routine for newborn screening	Pass	Left ear- pass Right ear- pass	Infant's hearing test are within normal limits
Newborn Cardiac Screen (At 24 hours)	Routine for newborn screening	Negative	Negative, pass	Infant's heart screening is within normal limits.

Lab Data and Diagnostics Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

Newborn Medications (7 points)

Brand/Generic	Aquamephyton (Vitamin K)	Illotycin (Erythromycin Ointment)	Hepatitis B Vaccine		
Dose	1 mg	0.5%	10 mcg		
Frequency	once	once	once		
Route	INJ	ophthalmic	INJ		
Classification	Fat soluble vitamin	Macrolides	Immune globulin		
Mechanism of Action	Prevention of bleeding due to hypoprothrombinemia	Suppresses protein synthesis at the level of the 50S bacterial ribosome.	Confers passive immunity to hepatitis B infection		
Reason Client Taking	Prevention of hemorrhagic disease	prophylaxis	Prevention of hep b infection		
Contraindications (2)	Impaired liver function, hypersensitivity	Hypersensitivity, hypokalemia	Hypersensitivity, thrombocytopenia		
Side Effects/Adverse Reactions (2)	Gastric upset, erythema	Nausea, vomiting	Dizziness, pruritus		
Nursing Considerations (2)	Monitor for frank and occult bleeding, monitor for side effects and adverse reactions	Monitor bowel function, assess for infection	Assess patient for signs of anaphylaxis, Epinephrine and antihistamines should be available		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Prothrombin time	Liver functions	none		
Client Teaching needs (2)	Advise parents to report any symptoms of unusual bleeding, emphasize importance of frequent lab testing	Notify health provider if fever or diarrhea occur, report signs of	Explain the use and purpose of hep B immune globulin therapy, advise patient to		

			report symptoms		
		superinfection.	**of anaphylaxis immediately.**		

Medications Reference (APA):

Vallerand, A. H., Sanoski, C. A., & Quiring, C. (2019). *Daviss drug guide for nurses*. Philadelphia, PA: F.A. Davis Company.

Newborn Assessment (20 points)

Area	Your Assessment	Expected Variations and Findings *This can be found in your book on page 645*	If assessment finding different from expectation, what is the clinical significance?
Skin	**Yellow**	**Normal: smooth, flexible, good skin turgor, well hydrated, warm**	**Neonate has a high bilirubin level**
Head	**normocephalic**	**Normal: normocephalic**	
Fontanels	**soft**	**Normal: Soft**	
Face	**normal**	**Normal: full cheeks, symmetric**	
Eyes	**normal**	**Normal: clear and symmetrically placed on face; online with ears**	
Nose	**normal**	**Normal: small , placement in the midline and narrow**	
Mouth	**Dry mucous membranes**	**Normal: aligned in midline, symmetric, intact soft and hard palate**	**Neonate has high bilirubin level**
Ears	**normal**	**Normal: soft and pliable with quick recoil when folded and released**	
Neck	**normal**	**Normal: short, creased, moves freely**	
Chest	**normal**	**Normal: round, symmetric, smaller than head**	

Breath Sounds	normal	Normal: clear	

Heart Sounds	normal	Normal: S1, S2	
Abdomen	nondistended	Normal: nondistended	
Bowel Sounds	Active x4	Normal: active bowel sounds in 4 quadrants	
Umbilical Cord	moist	Moist-dry	
Genitals	normal	normal	
Anus	normal	normal	
Extremities	normal	normal	
Spine	normal	normal	
Safety • Matching bands with parents • Hugs tag • Sleep position	Infant is laying on back. Hugs tag is on and bands match with parents	Matching bands, back to sleep, hugs tag activated	

Complete the Ballard Scale grid at the end to determine if this infant is SGA, AGA, or LGA—<mark>be sure to show your work</mark>

What was your determination? AGA

Are there any complications expected for a baby in this classification? none

Vital Signs, 3 sets (6 points)

Time	Temperature	Pulse	Respirations
Birth	100.4 F	128	60
4 Hours After Birth	98.9 F	144	52
At the Time of Your Assessment	99.1 F	105	65

Vital Sign Trends: The infant's vital signs pulse was slightly lower than the normal range at the time of my assessment and the temperature was elevated at birth and at the time of the assessment.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
2000	**NIPS**	**N/A**	**0**	**N/A**	**N/A**

Summary of Assessment (4 points)

Discuss the clinical significance of the findings from your physical assessment:

The neonate was delivered on 6/9/20 at 1300 by spontaneous vaginal delivery with a loose nuchal cord x1. Apgar scores were 8 and 9. Neonate is 39 +2 weeks and AGA. Prenatal history is uncomplicated. Birth weight 8 lbs 3 oz, 20.47 inches long. Upon assessment, neonate has yellowing skin and dry mucous membranes in the mouth. Bilirubin level is 13.2 and neonate is under bili lights and on a bili blanket. Neonate has not been breastfeeding at regular intervals, so he is now being supplemented with formula. Bilirubin levels will be drawn again between 5 and 6 am.

Nursing Interventions and Medical Treatments for the Newborn (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Bili blanket (T)	**continuous**	

		Neonate has an elevated bilirubin level. Continuous exposure under lights will help reduce the serum level.
Overhead lights (T)	**continuous**	**Neonate has an elevated bilirubin level. Continuous exposure under lights will help reduce the serum level.**
Supplementation with formula (T)	**During feeding time**	**The mom is to limit feedings to 30 minutes with the last 10 minutes giving the infant formula. This should help the neonate pass more stool.**
Bilirubin redraw (T)	**Between 5 and 6 am**	**The neonate's bilirubin needs to be rechecked to verify whether the serum level is within normal range.**

Discharge Planning (2 points)

Discharge location: Home with both parents.

Equipment needs (if applicable): none

Follow up plan (include plan for newborn ONLY): The infant has a bilirubin redraw between 5 and 6 am tomorrow morning.

Education needs: The parents need education about keeping the infant under bili lights as much as possible to assist with serum levels.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of them must be education related i.e. the interventions must be education for the client."

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Rational (1 pt each) Explain why the nursing diagnosis was chosen	Intervention/ Rational (2 per dx) (1 pt each) Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	Evaluation (1 pt each) • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. **Deficient Knowledge related to hyperbilirubinemia as evidenced by high bilirubin**	**Infant has high bilirubin serum level**	1. Reinforce learning through frequent repetition and follow-up sessions. **Rationale: The infant's parents need to be included in the plan of care.** **2.** Consider the context, timing, and order of how information is presented. **Rationale: The mom was emotional at times and may not have been receptive to learning.**	**Parent's will be able to describe the rationale for therapy/treatment options.**
2. **Risk for infection related to neonatal immune**	**The neonate is immunocompromised so he could**	1. Follow meticulous hand hygiene when working with	**Remain free from symptoms of infection**

system as evidenced by need for prophylaxis treatments	**possibly get an infection.**	**children. Rationale: Hand hygiene can prevent transferring microbes to neonate. 2.Cluster nursing procedures to decrease number of contacts with infants. Rationale: Each subsequent contact with an infant can potentially introduce new bacteria.**	**during contact with health care providers.**
3. **Risk for impaired skin integrity related to circumcision as evidenced by erythema in the area.**	**The neonate had a circumcision that needs to be properly taken care of or it can become a skin issue.**	1. **Inspect and monitor skin daily. Rationale: The affected should be inspected with each diaper change. 2. Assess caregiver ability to recognize potential risk for skin breakdown. Rationale: Parent' should be taught abnormal signs to look for in new circumcisions.**	**Parents will verbalize understanding of cleaning genital area and reapplying petroleum jelly.**
4. **Risk for imbalanced body temperature related to neonate's inability to regulate body heat as evidenced by temperature fluctuations.**	**The neonate's temperature was slightly elevated at the time of the assessment.**	1. **Keep the room temperature at 72 F. Rationale: Since the infant is not able to regulate his own temperature, the room needs to be warm. 2. Measure temperature in the axilla every 4 hours. Rationale: Measuring the temperature on an infant less than 4 weeks anywhere**	**Infant will maintain a temperature within normal range during shift.**

		besides the axilla may provide an inaccurate reading.	

Other References (APA):

Ladwig, G. B., Ackley, B. J., & Makic, M. B. F. (2017). *Mosbys guide to nursing diagnosis*. St. Louis: Mosby.

## Ballard Gestational Age Scale

Neuromuscular Maturity

Score	−1	0	1	2	3	4	5
Posture							
Square window (wrist)	> 90°	90°	60°	45°	30°	0°	
Arm recoil		180°	140−180°	110−140°	90−110°	< 90°	
Popliteal angle	180°	160°	140°	120°	100°	90°	< 90°
Scarf sign							
Heel to ear							

Physical Maturity

							Maturity Rating	
Skin	Sticky, friable, transparent	Gelatinous, red, translucent	Smooth, pink; visible veins	Superficial peeling and/or rash; few veins	Cracking, pale areas; rare veins	Parchment, deep cracking; no vessels	Leathery, cracked, wrinkled	
Lanugo	None	Sparse	Abundant	Thinning	Bald areas	Mostly bald	Score	Weeks
Plantar surface	Heel-toe 40−50 mm: −1 < 40 mm: −2	> 50 mm, no crease	Faint red marks	Anterior transverse crease only	Creases anterior 2/3	Creases over entire sole	−10	20
							−5	22
							0	24
Breast	Imperceptible	Barely perceptible	Flat areola, no bud	Stippled areola, 1−2 mm bud	Raised areola, 3−4 mm bud	Full areola, 5−10 mm bud	5	26
							10	28
Eye/Ear	Lids fused loosely: −1 tightly: −2	Lids open; pinna flat; stays folded	Slightly curved pinna; soft; slow recoil	Well curved pinna; soft but ready recoil	Formed and firm, instant recoil	Thick cartilage, ear stiff	15	30
							20	32
							25	34
Genitals (male)	Scrotum flat, smooth	Scrotum empty, faint rugae	Testes in upper canal, rare rugae	Testes descending, few rugae	Testes down, good rugae	Testes pendulous, deep rugae	30	36
							35	38
							40	40
Genitals (female)	Clitoris prominent, labia flat	Clitoris prominent, small labia minora	Clitoris prominent, enlarging minora	Majora and minora equally prominent	Majora large, minora small	Majora cover clitoris and minora	45	42
							50	44

CLASSIFICATION OF NEWBORNS (BOTH SEXES) BY INTRAUTERINE GROWTH AND GESTATIONAL AGE [1,2]

NAME_____   DATE OF EXAM_____   LENGTH_____

HOSPITAL NO._____   SEX_____   HEAD CIRC._____

RACE_____   BIRTH WEIGHT_____   GESTATIONAL AGE_____

DATE OF BIRTH_____

WEIGHT PERCENTILES

LENGTH PERCENTILES

HEAD CIRCUMFERENCE PERCENTILES
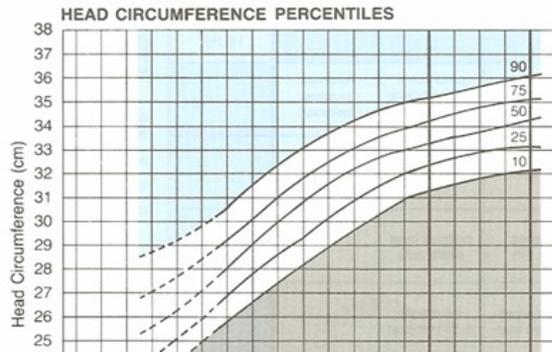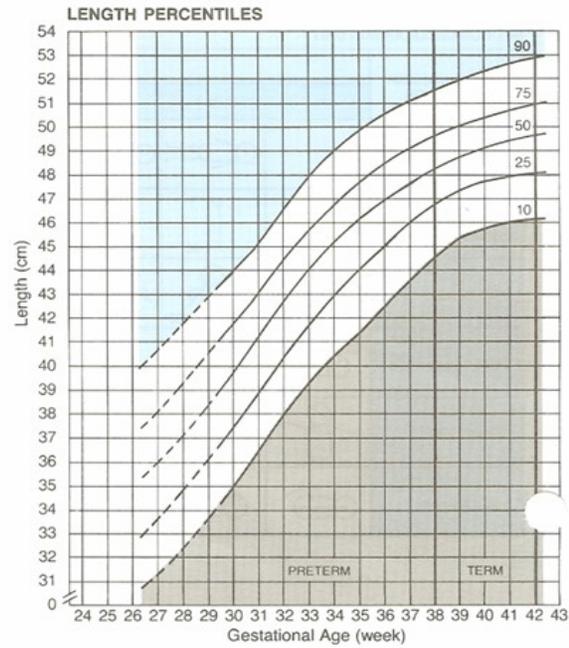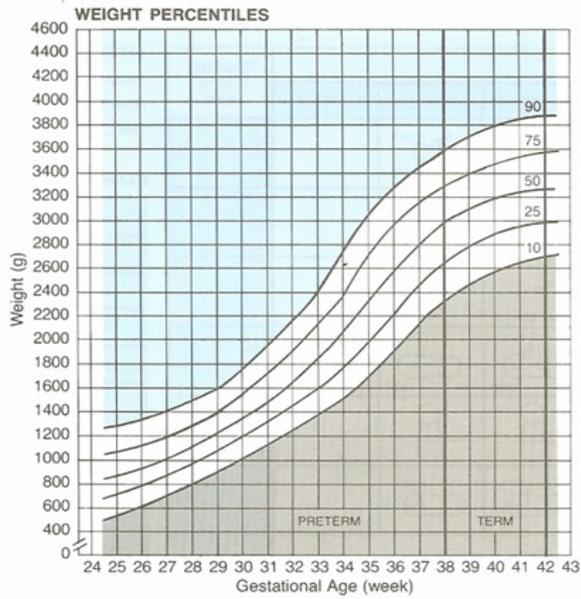
CLASSIFICATION OF INFANT*	Weight	Length	Head Circ.
Large for Gestational Age (LGA) (>90th percentile)			
Appropriate for Gestational Age (AGA) (10th to 90th percentile)			
Small for Gestational Age (SGA) (<10th percentile)			

N432 Newborn Care Plan Grading Rubric

Student Name:

Demographics	10 points	5 points	0 points	Points
Demographics • Date/time of clinical assessment • Date & time of birth • Patient initials • Age in hours at clinical assessment • Gender • Race/Ethnicity • Weight at birth and at time of assessment • Length at birth • Head circumference at birth • Chest circumference at birth	Includes complete information regarding the patient. Each section is filled out appropriately with correct labeling. **10 pts**	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	
Mother/Family Medical History	**15 points**	**14-10 points**	**9-0 points**	**Points**

Prenatal History of the mother • When prenatal care started • Abnormal prenatal labs/diagnostics • Prenatal complications • Smoking/drugs during pregnancy **Labor History of Mother** • Gestation at onset of labor • Length of labor • ROM • Medications in labor • Complications of labor & delivery **Past Surgical History** • All previous surgeries should be listed **Family History** • Pertinent to infant **Social History** • Pertinent to infant • Father of baby involvement **Living situation** **Education level** • If applicable to parents' learning barriers or care of infant	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. **15 pts**	1 or more of the key components is missing detailed information.	More than two of the key components are not filled in correctly	

Birth History	10 points	5 point	0 points	Points

Birth History
• Length of second stage of labor
• Type of delivery
• Complications of birth
• APGAR scores
   o 1 minute
   o 5 minutes
• Resuscitation methods beyond the *normal need*
	Every key component of the birth history is filled in correctly with information.
	
	10 pts
		Two of the key components are missing in the birth history. The birth history is lacking important information to help determine what has happened to the patient.	No birth history included.	

Feeding Techniques	10 points	5-9 points	0 points	Points
Feeding Technique Type • Specify breast or bottle feeding **If Breastfeeding:** • LATCH score **If Bottle Feeding:** • Positioning of bottle • Suck strength • Amount **Percentage of Weight Loss** • To be done at the time of assessment • <mark>Include calculations (show your work)</mark>	All key components are filled in correctly. The student was able to identify the effectiveness of the feeding technique. Calculation of weight loss is accurate.	One of the key components is missing or not understood correctly. **9 pts**	Student did not complete this section.	

• Include normal weight loss for an infant of this age • Include whether or not this newborn's weight loss is within normal limits				
Intake and Output	**8 points**	**1-7 points**	**0 points**	**Points**

Intake
 • Breastfeeding
  o Feeding frequency
  o Length of feeding session
  o One or both breasts
 • Bottle Feeding
  o Frequency
  o Volume of formula per session
 • NG or OG Feeding
  o Frequency
  o Volume
 • IV Feeding
  o Rate of flow
  o Volume in 24 hours
 	
Output
 • Age (in hours) of first void
 • Voiding patterns
  o Number of times in 24 hours
 • Age (in hours) of first stool
 • Stool patterns
  o Type
	All of the key components of the intake and output were addressed. Student demonstrates an understanding of intake and output.
	
	8 pts
		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.	Student did not complete this section.	

o Color o Consistency o Number of times in 24 hours				

Laboratory/Diagnostic 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.
  • Utilize bilitool.org for bilirubin levels
 	
Laboratory Data
  • Explanation of why the test was ordered for THIS client
	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	1 or more of the patient's labs were not reported completely with normal values or patient results. Lab correlation did not completely demonstrate student's understanding of	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	

	correlate abnormal laboratory findings to the patient's particular disease process.	correlation. **14 pts- See my comments**	minimum of 1 reference.	
• Expected results • Client's results • Interpretation of results • Newborn screen results MAY NOT be available for every client as the results may not come back until after discharge **Rational for abnormal values** • Written in complete sentences with APA citations • Explanation of the laboratory abnormality in this patient • 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				

Current Medications	**7 points**	**6-2 points**	**1-0 points**	**Points**

Current Medications
• Requirements of all inpatient hospital medications given to the newborn
• 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 10 medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.
	
	7 pts
		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 Exam	20 points	19-5 points	4-0 points	Points
• Gestational age assessment using Ballard scale • Completion of a head to toe assessment done on the students own and not copied from the client's chart • Safety risk assessment • **No safety risk assessment will result in a zero for the section**	All key components are met including a complete head to toe assessment and safety risk assessment.	One or more of the key components is missing from a given section. Each body system is worth points as listed on care plan. **19 pts— Showing work on Ballard scale**	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	6 points		3 points	0 points	Points
Vital Signs • 3 sets of vital signs are recorded	All the key components were met for this section (with 3 sets of vital signs)		Only one set of vital signs were	Student did not	

with the appropriate labels attached • Includes a set at birth, 4 hours after birth, and at the time of your assessment • Student highlighted the abnormal vital signs • Student wrote a summary of the vital sign trends	and student has a good understanding of abnormal vital signs. **6 pts**	completely recorded and one of the key components were missing.	complete this section	

Pain Assessment	2 points	1 point	0 points	Points
Pain assessment • Pain assessment was addressed and recorded twice throughout the care of this patient • 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. **2 pts**	One assessment is incomplete.	Student did not complete this section	

Summary of Assessment	4 points	0-3 points	Points
• Discussion of the clinical significance of the assessment findings • Written in a paragraph form	Ass of the key components of the summary are addressed. It is written in a paragraph format with no less than 5 sentences, in the	One or more of the key components is missing. Difficult to determine if the student has a thorough	

with no less than 5 sentences	student's own words. **4 pts**	understanding.	
Nursing Care Interventions	**6 points**	**0-5 points**	**Points**
Nursing Interventions • List the nursing interventions and medical treatments utilized with your client • Includes a rationale as to why the intervention is carried out or should be carried out for the client • Differentiates between nursing interventions (N) and medical interventions (M) • Include the frequency that the intervention is being performed	All of the key components are addressed. Student demonstrates an understanding of the nursing care and interventions needed/provided. **6 pts**	One or more of the key components is missing. Difficult to determine if the student has a thorough understanding.	

Discharge Planning	**2 points**	**1 point**	**0 point**	**Points**
Discharge Planning • Discharge location • Equipment needs (if applicable) • Follow up plan o Include plan for newborn ONLY	All the key components of the discharge summary were addressed. Student demonstrated an understanding of	One or more of the key components of the nursing care was missing, therefore it was difficult to determine if the	Student did not complete this section	

• Education needs	the nursing care. **2 pts**	student had a thorough understanding of the nursing care.		
Nursing Diagnosis	**30 points**	**5-29 points**	**4-0 points**	**Points**

Nursing Diagnosis
• List 4 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
• Outcome/goal for each intervention is required
  o These should be specific and individualized for THIS client
  o These should be easily measurable
• Correct priority of the nursing
	All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.
	
	30 pts
		One or more of the nursing diagnosis/rational/intervention sections was incomplete or not appropriate to the patient Each section is worth 3 points. Prioritization was not appropriate.	More than 2 of the nursing diagnosis sections were incomplete or inappropriate. Prioritization is dangerously inappropriate.	

diagnosis
- Appropriate evaluation

Teaching Topics
- List 2 priority teaching items
- Includes 1 expected outcome for each teaching topic
- Includes how the information would be taught
- Includes an expected outcome

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 **5 pts**	APA format was used but not correct. Several grammar errors or overall poor writing style was used. Content was difficult to understand.	No APA format. Grammar or writing style did not demonstrate collegiate level writing.	

Instructor Comments: **Well done.**				
Total Points Awarded	147/150=98%			