TEMPLE COLLEGE VN PROGRAM

Written Nursing Process - Grading Rubric Guidelines

Assessment:

A. **General: Presentation & Legibility:**
- Must be Typed
- Your final product should look as if it is being presented to the BON for an audit.
- Only type in black ink
- Only highlight your abnormal findings in yellow

B. **Complete:**
- Fill in all blanks with head-to-toe assessment findings
- You must check Y or N in specific areas; then you must elaborate if specified
- If elaboration is not necessary, you may draw one line in the blank
- Do not use N/A this could stand for not assessed
- At the end of assessment sections, blank lines are provided and you must provide additional information if any abnormal findings are documented.
    - For example: If you circle bruising under skin, you would need to elaborate on the size, color, and location.
- **DO NOT LEAVE ANY BLANK LINES**
    - Failure to circle a Y or N response or failure to draw a line will result in points off
    - Each blank will be – 1 point up to 40 points off your grade.

C. **Accurate:**
- Assessment findings need to be consistent throughout the assignment.
    - Do not put the patient has a left leg amputation in one area then document equal lower extremity pulses in another.
    - Incongruencies can result in up to 40 points off your grade.

D. **Correct terms/spelling:**
- Correct terms and spelling must be used in documentation.
- Be accurate and specific. Avoid vague terms such as: Normal, strange, tolerated well, average, bad, poor, odd, good
- Only use approved abbreviations found in your textbooks.
- If you are unsure about the abbreviation- spell it out.
- Do not use any abbreviations found on JACHO's Do not use list
- This can result in up to 10 points off your grade

2019 Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg) * Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

E. **Variations highlighted**:
- All findings on the assessment that are not within defined ranges in your textbook should be highlighted
  - Another way to look at it is if a healthy 20 year old would not have it, it should be highlighted.
- The highlighted abnormal findings will then be used to formulate your nursing diagnosis
- Unhighlighted abnormalities may result in up to 20 points off your grade

F. Nursing Diagnosis:
- One diagnosis must be knowledge deficit
- The second should apply to your assessment and may not be pain.
  - If you have questions or difficulty selecting a nursing diagnosis, speak with your instructor

G. Patient Strengths:
- These are attributes that contribute to the patient's health in a positive manner

H. Lab sheet:
- All ranges must be filled in even if the client did not have lab drawn.
- If the client did not have the lab, draw a single line under client's results.
- If the client did not have the lab, put a general purpose for the lab test. If the client had the lab put the specific purpose for the test.
- Blanks will be 1 point each for up to 10 points off your grade

I. **Medication Sheet**

- Must complete 8 medications. If your patient does not have 8 medications see your instructor for additional information.
- Make sure the medication, dose, route, and time are in the first box
- Make sure the indication is specific to patient, not the general reason.
- Specific side-effects you need to monitor your patient for. DO NOT Copy/Paste every side effect from the book.
- Nursing implications: What do you need to assess prior to administering this medication? How are you going to assess for the side-effects/ life threatening adverse reactions? What do you need to educate your client on?

Care Plans

- Must complete 2 care plans.
- One must be Knowledge Deficit. The second must apply to your patient's physical assessment. (may not use pain)

Related to:

- Select the most appropriate option. If you choose other it must be approved by your instructor.

AMB:

- This should be the number 1 piece of subjective or objective data that supports your nursing diagnosis. For example: Pain would be the pain score.

Nursing diagnosis should be prioritized based on Maslow's Hierarchy of needs:

- Physiologic, safety and security needs are Prioritized as High
- Diagnosis pertaining to Airway, Breathing, or Circulation are High
- Risk for diagnosis is prioritized as Low

Objective and Subjective Data:

- All care plans must have a minimum of ***1 subjective finding and 2 objective findings.***

Planning:

- Select the outcome and time for your specific client.
- If you choose fill in the blank discuss it with your instructor first. Outcomes should be specific and measurable.

Implementation:

- This semester you must select 4 interventions and document your implementation.
  - **Out of the 4 interventions**, *ONLY 1 can be assessment. Other interventions need to be actions that will help you meet the outcome you selected*.
    - ***More than 1 assessment intervention will result in zero points for this section***
  - The implementation sections should look like nursing notes. They start with date, time, documentation and end with your initials.
    - If your intervention states assess pain every 4 hours, you should have documentation to support the assessment of pain every 4 hours during your shift. For example
      - 01/10/2022 at 1000 patient states pain is 9/10. ----MM, RN
      - 01/10/2022 at 1400 patient states pain is 3/10. ----MM, RN

Outcome:

- Should be documented as a nursing note.
  - Date, time, documentation, was the goal met or not met at this time, and signature.
  - The documentation should provide the patient's response to the outcome you selected.
    - 01/10/2022 at 1800 patient states pain is 2/10. Goal met.----MM, RN