

Patient Care Summary Assignment Rubric

Patient Care Summary (PCS)		75 Total Possible Points
Page 1		
Patient Demographics	6.5 points	
Vital Signs	7 points	
Nutrition	3 points	
Hygiene	2 points	
Mobility	1 point	
Intake/ Output	2 points	
Page 2		
Treatment & Procedures	1 point	
IV Site & Fluids	1 point	
Lab Test	11 points	
Page 3		
Drugs/Dose/Route/Time	4 points	
Classification	2 points	
Why	4 points	
Side Effects	4 points	
Nursing Implications	4 points	
Page 4		
Medical Diagnosis	½ point	
Disease definition & Patho	3 points	
Causes, Risk factors, etc.	4 points	
Signs and Symptoms	2 points	
Medical Treatment	2 points	
Nursing Care	3 points	
Reference	½ point	
Page 5		
Patient Teaching	6 points	
Safety	1.5 Points	
PCS Total Points		

Care Plan (CP)		25 Total Possible Points
Maslow's Priority	1/2 point	
Related to	1/2 point	
As manifested by	1/2 point	
Subjective data	2 points	
Objective data	2 points	
Outcome	1 point	
Time	1 point	
Implementation	15 points	
Evaluation	2.5 points	
CP Total Points		

PCS points _____ + CP Points _____ = _____ Final Grade

Student Name: Paul Briery

Date:

Clinical Instructor: Dr. X

TEMPLE COLLEGE VOCATIONAL NURSING PATIENT CARE SUMMARY

CLINICAL- LVN TRAINING II

Patient's Initials:	Age:	Gender:	Unit/Rm#	Admitting Physician:							
Date of Admission:	Admitting Diagnosis:							Code Status: Full Code DNI DNR			
Allergies (Drugs and/or Food):								Height:		Weight:	
History of present illness: (What brought the patient to the hospital?)											
Surgical procedure on this admission (If applicable):											
Vital Signs <u>Minimum</u> <u>of 2 Sets</u> <u>of V/S</u>	Frequency (circle one): Daily Every 12 hours Every 8 hours Every 6 hours Every 4 hours Other:_____										
	Date & Time	Temp & Route	Pulse & Location	Respirations	Blood Pressure & Location			O ₂ Sat & Oxygen			
Pain	No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, Describe: _____										
Nutrition	Day 1: Diet Type _____ NPO <input type="checkbox"/>			Hygiene							
	Breakfast: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> 25% <input type="checkbox"/> 0%				<input type="checkbox"/> Bath	Oral Care		Shave		Peri Care	
	Lunch: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> 25% <input type="checkbox"/> 0%				<input type="checkbox"/> Shower						
	Dinner: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> 25% <input type="checkbox"/> 0%				<input type="checkbox"/> Self	<input type="checkbox"/> Self		<input type="checkbox"/> Self		<input type="checkbox"/> Self	
	If applicable: Tube Feed: (Specify type) _____ Tube Feeding Residual: _____				<input type="checkbox"/> Assist	<input type="checkbox"/> Assist		<input type="checkbox"/> Assist		<input type="checkbox"/> Assist	
					<input type="checkbox"/> Total	<input type="checkbox"/> Total		<input type="checkbox"/> Total		<input type="checkbox"/> Total	
<input type="checkbox"/> Refused				<input type="checkbox"/> Refused		<input type="checkbox"/> Refused		<input type="checkbox"/> Refused			
Mobility	Specify <input type="checkbox"/> BR <input type="checkbox"/> BRP <input type="checkbox"/> Ambulatory <input type="checkbox"/> Amb. Assist <input type="checkbox"/> Total Assistive Devices: _____										
Intake/Output	Intake						Output				
	7a-7p	PO	IV	NG & Flush	Enteral	Total	Urine	NG/Emesis	Stool	Drains	Total

Treatment/ Procedures	(Examples: Dressing changes, Blood Glucose Tests...)			
Intravenous Catheter (IV)	Location of IV Site: Type of IV Fluids: <ul style="list-style-type: none"> • Site • Fluids 			
Diagnostic Studies (List the following lab tests type, results, and significance of each)				
	Normal Value	Result & Date:	Result: High/Low?	<u>How</u> do the results apply to the patient?
WBC	4.1 - 10.7 /mm ³			
RBC	4.1 - 5.4 /mm ³			
HGB	12.5 - 16.4 g/dL			
HCT	38.3 - 51.2 mL/dL			
PLT	142 - 366 / mm ³			
BUN <i>Blood Urea Nitrogen</i>	6 - 24 mg/dL			
Creatinine	0.44 - 1.27 mg/dL			
Sodium	135 - 145 mEq/L			
Potassium	3.5 - 5.1 mEq/L			
Chloride	96 - 108 mEq/L			
PT/INR	PT: seconds			
	INR:			

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Drug/Dose/Route/Time	Classification	Why is the patient on this drug? <u>Be Specific</u>	Medication's Side Effects	Nursing Implications
Drug: Dose: Route: Time(s):				
Drug: Dose: Route: Time(s):				
Drug: Dose: Route: Time(s):				
Drug: Dose: Route: Time(s):				

Disease Research
Medical Diagnosis:
Disease Definition & Pathophysiology (Describe the processes & changes within the body that result in the <u>signs and symptoms</u> of the disease).
Describe the Causes, Risk Factors, Complications, and Disease Prognosis:
Cause: Risk Factors: Complications: Disease Prognosis:
Textbook Signs/Symptoms (<u>Underline</u> the signs and symptoms <u>your patient had</u>):
Textbook Medical Treatment:
Textbook Nursing Care:
Reference: (Name of the textbook and page number):

Describe the Teaching you did with your patient. <i>Patient Teaching: Briefly summarize your patient teaching including topic, content, method of evaluation, and results of evaluation)</i>	
Topic:	
Content:	
Patient education given to: <input type="checkbox"/> Patient <input type="checkbox"/> Family/Significant Others	
Method/s of patient teaching (Choose all that apply): <input type="checkbox"/> Verbal explanation <input type="checkbox"/> Handouts <input type="checkbox"/> Demonstration <input type="checkbox"/> Video	
Method & Results of Evaluation: <input type="checkbox"/> Patient/significant other verbalized understanding <input type="checkbox"/> Return demonstration <input type="checkbox"/> Restates information <input type="checkbox"/> Needs follow-up	
Community Resources/Referrals: What resources would your patient benefit from? (e.g., American Diabetes Association, Local health department, social services, chaplain, etc.)	
Safety Precautions:	
Describe the SAFETY issues you addressed with your patient: _____ _____ _____	Identify: <i>Select all that apply</i> <input type="checkbox"/> Call Light within reach <input type="checkbox"/> Nonskid footwear <input type="checkbox"/> Hand Hygiene <input type="checkbox"/> Side rails up X: 1 2 3 <input type="checkbox"/> Patient education <input type="checkbox"/> 2 Pt identifiers <input type="checkbox"/> Room orientation <input type="checkbox"/> Bed in lowest position