Criteria | Pts: | Available | Earned
---|---|---|---
1. Erikson’s stage of development identified & described for the patient Indicate which side of the conflict your patient is facing and state why | 10 points | | 

2. History, ROS, & subjective data collected & are appropriate | A | 5 points | 
3. Objective data collected & are appropriate | A | 5 points | 
4. Diagnostic data incorporated accurately | A | 5 points | 

5. Nursing diagnosis supported by data (in the HPI/physical assessment) or “S” component of the diagnostic statement (PES) | D | 5 points | 
6. Nursing diagnosis stated correctly x2; choose 1 as priority diagnosis | P | 5 points | 

7. Patient outcomes (properly identifies) | P | 5 points | 
8. Patient goal statement(s) written correctly (I per nursing diagnosis) | | 5 points | 

9. Patient goals realistic to scope of problem | P | 5 points | 

10. Interventions: (Must have 10 total)

   - Realistic | I | 5 points | 
   - Related to nursing diagnosis | 5 points | 
   - Related to achieving the goals/outcomes | 5 points | 
   - Patient-centered (individualized to your specific patient) | 5 points | 

11. Rationales correctly provided for each intervention | I | 5 points | 
12. References provided for each intervention using APA format for your citations & include page #s | I | 5 points | 
13. Evaluation written clearly and is relevant to goals | E | 5 points | 
14. Provide a copy of at least one scholarly article supporting a current EBP intervention. Use a new article with each careplan. | I | 5 points | 
15. Pathophysiology accurate and detailed in your own words; provide references using APA format for your citations & include page #s | 5 points | 

Grade Pass or Fail where Failure = Unsatisfactory

1
### Template for Weekly Care Plan NUR 320 Summer 2012

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Date:</th>
<th>Patient Initials:</th>
</tr>
</thead>
</table>

#### DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Occupation</th>
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</table>

#### HISTORY

**History of Present Illness (HPI)**
(Onset, duration, signs & symptoms)

**Past Medical History (PMH)**
(Co-existing illnesses, smoker?, substance use: tobacco, alcohol, illicit drugs?)

**Immunizations**

**Childhood Illnesses**

**Prior Hospitalizations**

**Past Surgeries**

**Home Medications:** List each drug name

**Hospital Medications:** List drug name with the pharmacological and therapeutic classifications for each.

**Are the home & hospital lists the same?**
If not, provide your rationale.

**Allergies**

**Family Health History**

**Admission Medical Diagnosis(es)**

**Today’s Medical Diagnosis(es)**

**Pathophysiology:**
Admission & Today’s Medical Diagnoses
Use your own words; provide citations using APA format (include page numbers).

#### Code Status

**Treatments**

<table>
<thead>
<tr>
<th>Diagnostic Tests</th>
<th>Result</th>
<th>Abnormal?</th>
<th>Significance</th>
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<tbody>
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</table>
Review of Systems (ROS) for Current Health Problems
(Patient's [or family's or reporting nurse's] SUBJECTIVE description of health status for each body system)

Highlight, underline, or boldface the patient's response; Write “denies” in the blank provided if patient does NOT have these symptoms:

General/Constitutional:

- Average weight, weight loss or gain, general state of health, sense of well-being, strength, ability to conduct usual activities, exercise tolerance?

Skin/Breast:

- Rash, itching, pigmentation, moisture or dryness, texture, changes in hair growth or loss, nail changes
- Breast lumps, tenderness, swelling, nipple discharge?

Eyes/Ears/Nose/Mouth/Throat:

- Headaches (location, time of onset, duration, precipitating factors), vertigo, lightheadedness, injury?
- Vision, double vision, tearing, blind spots, pain?
- Nose bleeding, colds, obstruction, discharge?
- Dental difficulties, gingival bleeding, dentures?
- Neck stiffness, pain, tenderness, masses in thyroid or other areas?

Cardiovascular:

- Precordial pain, substernal distress, palpitations, syncope, dyspnea on exertion, orthopnea, nocturnal paroxysmal dyspnea, edema, cyanosis, hypertension, heart murmurs, varicosities, phlebitis, claudication?

Respiratory:

- Pain (location, quality, relation to respiration), shortness of breath, wheezing, stridor, cough (time of day, of productive, amount in tablespoons or cups per day and color of sputum), hemoptysis, respiratory infections, tuberculosis (or exposure to tuberculosis), fever or night sweats?

Gastrointestinal:

- Appetite, dysphagia, indigestion, food idiosyncrasy, abdominal pain, heartburn, eructation, nausea, vomiting, hematemesis, jaundice, constipation, or diarrhea, abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling), flatulence, hemorrhoids, recent changes in bowel habits?

Genitourinary

- Urgency, frequency, dysuria, nocturia, hematuria, polyuria, oliguria, unusual (or change in) color of urine, stones, infections, nephritis, hesitancy, change in size of stream, dribbling, acute retention or incontinence, libido, potency, genital stores, discharge, venereal disease?
- (Female) Age of onset of menses, regularity, last period, dysmenorrhea, menorrhagia, or metrorrhagia, vaginal discharge, post-menopausal bleeding, dyspareunia, number and results of pregnancies (gravida, para):
Musculoskeletal:

- Pain, swelling, redness, or heat of muscles or joints, limitation of motion, muscular weakness, atrophy, cramps?

Neurologic/Psychiatric:

- Convulsions, paralyses, tremor, incoordination, paresthesias, difficulties with memory of speech, sensory or motor disturbances, or muscular coordination (ataxia, tremor)
- Predominant mood “nervousness” (define), emotional problems, anxiety, depression, previous psychiatric care, unusual perceptions, hallucinations?

Allergic/Immunologic/Lymphatic/Endocrine:

- Reactions to drugs, food, insects, skin rashes, trouble breathing?
- Anemia, bleeding tendency, previous transfusions, and reactions, Rh incompatibility?
- Local or general lymph node enlargement or tenderness. -Polydipsia, polyuria, asthenia, hormone therapy, growth, secondary sexual development, intolerance to heat or cold?
<table>
<thead>
<tr>
<th>S: SUBJECTIVE DATA (Today’s Chief Complaint)</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>O: PHYSICAL EXAMINATION/OBJECTIVE DATA</th>
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<tbody>
<tr>
<td>Vital Signs: (TPR, O₂ sat: RA or % of supplemental oxygen)</td>
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<tr>
<td>General Survey/Appearance</td>
</tr>
<tr>
<td>Level of Consciousness (LOC):</td>
</tr>
<tr>
<td>Respiratory:</td>
</tr>
<tr>
<td>(Inspect, palpate, percuss, auscultate)</td>
</tr>
<tr>
<td>Cardiac:</td>
</tr>
<tr>
<td>(Inspect, palpate, percuss, auscultate)</td>
</tr>
<tr>
<td>Neurologic:</td>
</tr>
<tr>
<td>(Speech, pupils reflexes, grips, sensation, gait)</td>
</tr>
<tr>
<td>Abdomen:</td>
</tr>
<tr>
<td>(Inspect, auscultate, percuss, palpate)</td>
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<tr>
<td>Stools</td>
</tr>
<tr>
<td>Renal/genitourinary:</td>
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<tr>
<td>(I/O balance; normal = 0.5 – 1 mL/kg/hour)</td>
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<tr>
<td>Musculoskeletal:</td>
</tr>
<tr>
<td>(Inspect, palpate)</td>
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<tr>
<td>Skin:</td>
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<tr>
<td>(Lesions, IV sites)</td>
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</tbody>
</table>
**A: NURSING DIAGNOSIS** [PES: Problem, etiology, & symptoms {if indicated}]; (Must have 2 and demonstrate which one is PRIORITY by **HIGHLIGHTING**)

**P: PLAN:**
- Outcome(s) [What you want your patient to achieve]

**I: NURSING INTERVENTIONS:** (for priority problem); use APA format to cite your references & include page numbers.

1. Rationale with reference:

2. Rationale with reference:

3. Rationale with reference:

4. Rationale with reference:

5. Rationale with reference:
E: EVALUATION: (Met outcome? AEB........); also reflects what things you are going to monitor/measure to determine if the outcome has been met.
## A: NURSING DIAGNOSIS # 2 (for secondary problem) [PES: Problem, etiology, & symptoms {if indicated}]

## P: PLAN:

**Outcome(s) [What you want your patient to achieve]**

Goal statement(s): [Must have subject, action verb, date/time, and performance criteria: AEB (as evidenced by)]

## I: NURSING INTERVENTIONS: (for secondary problem); use APA format to cite your references & include page #s.

1. Rationale with reference:

2. Rationale with reference:

3. Rationale with reference:

4. Rationale with reference:

5. Rationale with reference:
**EVALUATION:** (Met outcome? AEB........); also reflects what things you are going to monitor/measure to determine if the outcome has been met.

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Erikson’s 8 stages of development

- **EARLY INFANCY (0-2)**
  - Trust vs. mistrust
  - Is everything OK?

- **LATE INFANCY (2-3)**
  - Autonomy vs. shame, doubt
  - Let me do it

- **MIDDLE CHILDHOOD**
  - Initiative vs. guilt
  - What can I imagine?
  - Industry vs. inferiority
  - Can I really do this?

- **EARLY CHILDHOOD (4-5)**
  - Generativity vs. stagnation
  - What can I contribute?

- **MIDDLE ADULTHOOD**
  - Generativity vs. stagnation
  - What can I contribute?

- **LATE ADULTHOOD**
  - Integrity vs. despair
  - Does my life have meaning?

- **EARLY ADULTHOOD**
  - Intimacy vs. isolation
  - Can I commit myself?

- **ADOLESCENCE**
  - Identity vs. identity confusion
  - Who am I?

**KEY:**
- **STAGE**
- **Conflict**
- **Basic Issue**

Source: Erik H. Erikson