# NURSING PROCESS CARE PLAN FORMAT EVALUATION

**PATIENT’S INITIALS:**

**DATES OF CARE:**

**STUDENT’S NAME:**

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>ANALYSIS</th>
<th>PLANNING</th>
<th>IMPLEMENTATION</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUPPORTIVE DATA</strong></td>
<td><strong>NURSING DIAGNOSIS</strong></td>
<td><strong>PATIENT GOALS/OUTCOME CRITERIA</strong></td>
<td><strong>NURSING ACTIONS</strong></td>
<td><strong>SCIENTIFIC PRINCIPLES/RATIONALE</strong></td>
</tr>
<tr>
<td>S. What the client says about this problem</td>
<td>Statement of Problem (Nursing diagnosis [NANDA List] plus etiology)</td>
<td>Goal Statement</td>
<td>Actions to relieve problem and help client achieve goal (use textbooks)</td>
<td>Tells why each action should help achieve the goal</td>
</tr>
<tr>
<td>O. What you observe: see, hear, feel, smell, and measure</td>
<td>NOT doctor’s diagnosis</td>
<td>Outcome criteria define goals. They define what will be observed when goal is met</td>
<td>Each must be specific and complete statements, including who, what, where, when, how, how long, and how often, etc.</td>
<td>Must have statement for each action</td>
</tr>
<tr>
<td>+ Client lab values, test results</td>
<td>Only one diagnosis per page</td>
<td>Provide time frame</td>
<td>Label: I/Independent actions nurses can do without doctor’s order</td>
<td></td>
</tr>
<tr>
<td>+ Medications</td>
<td>Are measurable</td>
<td></td>
<td>D/Dependent – what the doctor orders for this problem</td>
<td></td>
</tr>
<tr>
<td>+ Doctor’s diagnosis</td>
<td>Both goals and outcome criteria stated as behavioral objective</td>
<td></td>
<td>C/Collaborative – require knowledge, skill, and expertise of another health care professional</td>
<td></td>
</tr>
<tr>
<td>From this data, the reader must be able to tell that he/she really has a problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Supportive Data**
- S. What the client says about this problem
- O. What you observe: see, hear, feel, smell, and measure
- + Client lab values, test results
- + Medications
- + Doctor’s diagnosis

**Nursing Diagnosis**
- Statement of Problem (Nursing diagnosis [NANDA List] plus etiology)
- Only one diagnosis per page

**Patient Goals/Outcome Criteria**
- Goal Statement
- Outcome criteria define goals. They define what will be observed when goal is met
- Provide time frame
- Are measurable
- Both goals and outcome criteria stated as behavioral objective

**Nursing Actions**
- Actions to relieve problem and help client achieve goal (use textbooks)
- Each must be specific and complete statements, including who, what, where, when, how, how long, and how often, etc.
- Label: I/Independent actions nurses can do without doctor’s order
- D/Dependent – what the doctor orders for this problem
- C/Collaborative – require knowledge, skill, and expertise of another health care professional

**Scientific Principles/Rationale**
- Tells why each action should help achieve the goal
- Must have statement for each action

**Observations/Conclusions**
- Have goals been partially or fully met?
- Describe in terms of the outcome criteria
- Should plan be revised or continued?
### NURSING PROCESS CARE PLAN FORMAT

**PATIENT’S INITIALS:** ________________  
**STUDENT’S NAME:** ________________  
**DATES OF CARE:** ________________

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>ANALYSIS</th>
<th>PLANNING</th>
<th>IMPLEMENTATION</th>
<th>SCIENTIFIC PRINCIPLES/ RATIONALE</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUPPORTIVE DATA</strong></td>
<td><strong>NURSING DIAGNOSIS</strong></td>
<td><strong>CLIENT GOALS/ OUTCOME CRITERIA</strong></td>
<td><strong>NURSING ACTIONS</strong></td>
<td><strong>OBSERVATIONS/ CONCLUSIONS</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Subjective:  
*I have to keep changing my pajamas because I can’t keep them dry.*  
| Urinary retention r/t neurologic impairment of the bladder secondary to diabetes | The patient will void sufficient amounts AEB | 1. Palpate the bladder q 4E. Ind. |
| **STG:** | **Objective:** | | | |
| ≥ Residual urine >100 ml | ≡ Residual urine >100 ml | STG:  
≡ No bladder distention and no overflow dribbling during my shift | 2. Implement techniques that encourage voiding like positioning and relaxation. Ind. |
| ≥ Small frequent voiding of less than 50 cc | ≡ Small frequent voiding of less than 50 cc | ≡ Has post void residual volume of less than 50 ml | 3. Catheterize the client if voiding is repeatedly unsuccessful or as ordered. Depend. |
| ≡ Dribbling (soiled pajamas and bed linen) | ≡ Dribbling (soiled pajamas and bed linen) | ≡ Demonstrates no s/s of a UTI by discharge | 4. Instruct the client in reportable s/s of UTI (chills, fever, flank pain, hematuria). Ind. |
| ≡ Bladder distention | ≡ Bladder distention | | | |

**SCIENTIFIC PRINCIPLES/ RATIONALE**

1. Palpation allows the nurse to determine the presence of bladder distention.
2. These measures may initiate the voiding reflex.
3. Catheterization is used as a last resort because of the danger of UTI.
4. Early recognition of infection facilitates prompt intervention to alleviate the problem.

**OBSERVATIONS/ CONCLUSIONS**

The patient had no bladder distention; however, had a PVR or 100 ml on my shift.

STG partially met. Continue with goals.

Patient not discharged during my shift.

Continue with LTG. Goal not met.