

NURSING PROCESS CARE PLAN FORMAT EVALUATION

PATIENT'S INITIALS: _____
 DATES OF CARE: _____

STUDENT'S NAME: _____

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

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<p><u>Subjective:</u> AI have to keep changing my pajamas because I can't keep them dry.@</p> <p><u>Objective:</u> ≡ Residual urine >100 ml ≡ Small frequent voiding of less than 50 cc ≡ Dribbling (soiled pajamas and bed linen) ≡ Bladder distention</p>	<p>Urinary retention r/t neurologic impairment of the bladder secondary to diabetes</p>	<p>The patient will void sufficient amounts AEB</p> <p><u>STG:</u> ≡ No bladder distention and no overflow dribbling during my shift</p> <p>≡ Has post void residual volume of less than 50 ml</p> <p><u>LTG:</u> ≡ Demonstrates no s/s of a UTI by discharge</p>	<ol style="list-style-type: none"> 1. Palpate the bladder q 4E. <u>Ind.</u> 2. Implement techniques that encourage voiding like positioning and relaxation. <u>Ind.</u> 3. Catheterize the client if voiding is repeatedly unsuccessful or as ordered. <u>Depend.</u> 4. Instruct the client in reportable s/s of UTI (chills, fever, flank pain, hematuria). <u>Ind.</u> 	<ol style="list-style-type: none"> 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. 	<p>The patient had no bladder distention; however, had a PVR or 100 ml on my shift.</p> <p>STG partially met. Continue with goals.</p> <p>Patient not discharged during my shift.</p> <p>Continue with LTG. Goal not met.</p>