**NURSING PROCESS CARE PLAN FORMAT EVALUATION**

**PATIENT’S INITIALS:**

**STUDENT’S NAME:**

**DATES OF CARE:**

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<th>ASSESSMENT</th>
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| 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
                  | From this data, the reader must be able to tell that he/she really has a problem
|                  | S. What the client says about this problem
                  | O. What you observe: see, hear, feel, smell, and measure
                  | NOT doctor’s diagnosis
                  | Only one diagnosis per page
|                  | NURSING DIAGNOSIS
|                  | (Nursing diagnosis [NANDA List] plus etiology)
|                  | NOT doctor’s diagnosis
|                  | Only one diagnosis per page
| NURSING DIAGNOSIS| Statement of Problem
                  | Goal Statement
| PATIENT GOALS/   | Outcome criteria define goals. They define what will be observed when goal is met
| OUTCOME          | Provide time frame
| CRITERIA         | Are measurable
|                  | Both goals and outcome criteria stated as behavioral objective
|                  | SCIENTIFIC PRINCIPLES/ RATIONALE
|                  | Tells why each action should help achieve the goal
|                  | 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
|                  | 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:**

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### SUPPORTIVE DATA

**Subjective:**
- I have to keep changing my pajamas because I can’t keep them dry.

**Objective:**
- Residual urine >100 ml
- Small frequent voiding of less than 50 cc
- Dribbling (soiled pajamas and bed linen)
- Bladder distention

### NURSING DIAGNOSIS

Urinary retention r/t neurologic impairment of the bladder secondary to diabetes

### CLIENT GOALS/OUTCOME CRITERIA

The patient will void sufficient amounts AEB

**STG:**
- No bladder distention and no overflow dribbling during my shift
- Has post void residual volume of less than 50 ml

**LTG:**
- Demonstrates no s/s of a UTI by discharge

### NURSING ACTIONS

1. Palpate the bladder q 4E. *Ind.*

2. Implement techniques that encourage voiding like positioning and relaxation. *Ind.*

3. Catheterize the client if voiding is repeatedly unsuccessful or as ordered. *Depend.*

4. Instruct the client in reportable s/s of UTI (chills, fever, flank pain, hematuria). *Ind.*

### 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.**