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Writing the best nursing care plan requires a step-by-step approach to complete the parts needed for a care plan correctly. This tutorial will walk you through developing a care plan. This guide has the ultimate database and list of nursing care plans (NCP) and nursing diagnosis samples for our student nurses and professional nurses to use—all for free! Care plan components, examples, objectives, and purposes are included with a detailed guide on writing an excellent nursing care plan or a template for your unit. A nursing care plan (NCP) is a formal process that correctly identifies existing needs and recognizes a client's potential needs or risks. Care plans provide a way of communication among nurses, their patients, and other healthcare providers to achieve healthcare outcomes. Without the nursing care planning process, the quality and consistency of patient care would be lost. Nursing care planning begins when the client is admitted to the agency and is continuously updated throughout in response to the client's changes in condition and evaluation of goal achievement. Planning and delivering individualized or patient-centered care is the basis for excellence in nursing practice. Care plans can be informal or formal: An informal nursing care plan is a strategy of action that exists in the nurse's mind. A formal nursing care plan is a written or computerized guide that organizes the client's care information. Formal care plans are further subdivided into standardized care plans and individualized care plans: Standardized care plans specify the nursing care for groups of clients with everyday needs. Individualized care plans are tailored to meet a specific client's unique needs or needs that are not addressed by the standardized care plan. Standardized care plans are pre-developed guides by the nursing staff and health care agencies to ensure that patients with a particular condition receive consistent care. These care plans are used to ensure that minimally acceptable criteria are met and to promote the efficient use of the nurse's time by removing the need to develop common activities that are done repeatedly for many of the clients on a nursing unit. Standardized care plans are not tailored to a patient's specific needs and goals and can provide a starting point for developing an individualized care plan. Care plans listed in this guide are standard care plans which can serve as a framework or direction to develop an individualized care plan. An individualized care plan care plan involves tailoring a standardized care plan to meet the specific needs and goals of the individual client and use approaches shown to be effective for a particular client. This approach allows more personalized and holistic care better suited to the client's unique needs, strengths, and goals. Additionally, individualized care plans can improve patient satisfaction. When patients feel that their care is tailored to their specific needs, they are more likely to feel heard and valued, leading to increased satisfaction with their care. This is particularly important in today's healthcare environment, where patient satisfaction is increasingly used as a quality measure. Tips on how to individualize a nursing care plan: Perform a comprehensive assessment of the patient's health, history, health status, and desired goals. Involve the patient in the care planning process by asking them about their health goals and preferences. By involving the client, nurses can ensure that the care plan is aligned with the patient's goals and preferences which can improve patient engagement and compliance with the care plan. Perform an ongoing assessment and evaluation as the patient's health and goals can change. Adjust the care plan accordingly. The following are the goals and objectives of writing a nursing care plan: Promote evidence-based nursing care and render pleasant and familiar conditions in hospitals or health centers. Support holistic care, which involves the whole person, including physical, psychological, social, and spiritual, with the management and prevention of the disease. Establish programs such as care pathways and care bundles. Care pathways involve a team effort to reach a consensus regarding standards of care and expected outcomes. In contrast, care bundles are related to best practices concerning care for a specific disease. Identify and distinguish goals and expected outcomes. Review communication and documentation of the care plan. Measure nursing care. The following are the purposes and importance of writing a nursing care plan: Defines nurse's role. Care plans help identify nurses' unique and independent role in attending to clients' overall health and well-being without relying entirely on a physician's orders or interventions. Provides direction for individualized care of the client. It serves as a roadmap for the care that will be provided to the patient and allows the nurse to think critically in developing interventions directly tailored to the individual. Continuity of care. Nurses from different shifts or departments can use the data to render the same quality and type of interventions to care for clients, therefore allowing clients to receive the most benefit from treatment. Coordinate care. Ensures that all members of the healthcare team are aware of the patient's care needs and the actions that need to be taken to meet those needs preventing gaps in care. Documentation. It should accurately outline which observations to make, what nursing actions to carry out, and what instructions the client or family members require. If nursing care is not documented correctly in the care plan, there is no evidence the care was provided. Serves as a guide for assigning a specific staff to a specific client. There are instances when a client's care needs to be assigned to staff with particular and precise skills. Monitor progress. To help track the patient's progress and make necessary adjustments to the care plan as the patient's health status and goals change. Serves as a guide for reimbursement. The insurance companies use the medical record to determine what they will pay concerning the hospital care received by the client. Defines client's goals. It benefits nurses and clients by involving them in their treatment and care. A nursing care plan (NCP) usually includes nursing diagnoses, client problems, expected outcomes, nursing interventions, and rationales. These components are elaborated on below: Client health assessment, medical results, and diagnostic reports are the first steps to developing a care plan. In particular, client assessment relates to the following areas and abilities: physical, emotional, sexual, psychosocial, cultural, spiritual/transpersonal, cognitive, functional, age-related, economic, and environmental. Information in this area can be subjective and objective. Nursing diagnosis. A nursing diagnosis is a statement that describes the patient's health issue or concern. It is based on the information gathered about the patient's health status during the assessment. Expected client outcomes. These are specific goals that will be achieved through nursing interventions. These may be long and short-term. Nursing interventions. These are specific actions that will be taken to address the nursing diagnosis and achieve expected outcomes. They should be based on best practices and evidence-based guidelines. Rationales. These are evidence-based explanations for the nursing interventions specified. Evaluation. These includes plans for monitoring and evaluating a patient's progress and making necessary adjustments to the care plan as the patient's health status and goals change. Nursing care plan formats are usually categorized or organized into four columns: (1) nursing diagnoses, (2) desired outcomes and goals, (3) nursing interventions, and (4) evaluation. Some agencies use a three-column plan where goals and evaluation are in the same column. Other agencies have a five-column plan that includes a column for assessment cues. The three-column plan has a column for nursing diagnosis, outcomes and evaluation, and interventions. Three-column nursing care plan format This format includes columns for nursing diagnosis, goals and outcomes, interventions, and evaluation. Four-column nursing care plan template Below is a document containing sample templates for the different nursing care plan formats. Please feel free to edit, modify, and share the template. Download: Printable Nursing Care Plan Templates and Formats Student care plans are more lengthy and detailed than care plans used by working nurses because they serve as a learning activity for the student nurse. Student nursing care plans are more detailed. Care plans by student nurses are usually required to be handwritten and have an additional column for "Rationale" or "Scientific Explanation" after the nursing interventions column. Rationales are scientific principles that explain the reasons for selecting a particular nursing intervention. How do you write a nursing care plan (NCP)? Just follow the steps below to develop a care plan for your client. The first step in writing a nursing care plan is to create a client database using assessment techniques and data collection methods (physical assessment, health history, interview, medical records review, and diagnostic studies). A client database includes all the health information gathered. In this step, the nurse can identify the related or risk factors and defining characteristics that can be used to formulate a nursing diagnosis. Some agencies or nursing schools have specific assessment formats you can use. Critical thinking is key in patient assessment, integrating knowledge across sciences and professional guidelines to inform evaluations. This process, crucial for complex clinical decision-making, aims to identify patients' healthcare needs effectively, leveraging a supportive environment and reliable information Now that you have information about the client's health, analyze, cluster, and organize the data to formulate your nursing diagnosis, priorities, and desired outcomes. Nursing diagnoses are a uniform way of identifying, focusing on and dealing with specific client needs and responses to actual and high-risk problems. Actual or potential health problems that can be prevented or resolved by independent nursing intervention are termed nursing diagnoses. We've detailed the steps on how to formulate your nursing diagnoses in this guide: Nursing Diagnosis (NDx): Complete Guide and List. Setting priorities involves establishing a preferential sequence for addressing nursing diagnoses and interventions. In this step, the nurse and the client begin planning which of the identified problems requires attention first. Diagnoses can be ranked and grouped as having a high, medium, or low priority. Life-threatening problems should be given high priority. A nursing diagnosis encompasses Maslow's Hierarchy of Needs and helps to prioritize and plan care based on patient-centered outcomes. In 1943, Abraham Maslow developed a hierarchy based on basic fundamental needs innate to all individuals. Basic physiological needs/goals must be met before higher needs/goals can be achieved, such as self-esteem and self-actualization. Physiological and safety needs are the basis for implementing nursing care and interventions. Thus, they are at the base of Maslow's pyramid, laying the foundation for physical and emotional health. Maslow's Hierarchy of Needs Basic Physiological Needs: Nutrition (water and food), elimination (Toileting), airway (suction)-breathing (oxygen)-circulation (pulse, cardiac monitor, blood pressure) (ABCs), sleep, sex, shelter, and exercise. Safety and Security: Injury prevention (side rails, call lights, hand hygiene, isolation, suicide precautions, fall precautions, car seats, helmets, seat belts), fostering a climate of trust and safety (therapeutic relationship), patient education (modifiable risk factors for stroke, heart disease). Love and Belonging: Foster supportive relationships, methods to avoid social isolation (bullying), employ active listening techniques, therapeutic communication, and sexual intimacy. Self-Esteem: Acceptance in the community, workforce, personal achievement, sense of control or empowerment, accepting one's physical appearance or body habitus. Self-Actualization: Empowering environment, spiritual growth, ability to recognize the point of view of others, reaching one's maximum potential. The client's health values and beliefs, priorities, resources available, and urgency are factors the nurse must consider when assigning priorities. Involve the client in the process to enhance cooperation. After assigning priorities for your nursing diagnosis, the nurse and the client set goals for each determined priority. Goals or desired outcomes describe what the nurse hopes to achieve by implementing the nursing interventions derived from the client's nursing diagnoses. Goals provide direction for planning interventions, serve as criteria for evaluating client progress, enable the client and nurse to determine which problems have been resolved, and help motivate the client and nurse by providing a sense of achievement. Examples of goals and desired outcomes. Notice how they're formatted and written. One overall goal is determined for each nursing diagnosis. The terms "goal outcomes" and "expected outcomes" are often used interchangeably. According to Hamilton and Price (2013), goals should be SMART. SMART stands for specific, measurable, attainable, realistic, and time-oriented goals. Specific. It should be clear, significant, and sensible for a goal to be effective. Measurable or Meaningful. Making sure a goal is measurable makes it easier to monitor progress and know when it reaches the desired result. Attainable or Action-Oriented. Goals should be flexible but remain possible. Realistic or Results-Oriented. This is important to look forward to effective and successful outcomes by keeping in mind the available resources at hand. Timely or Time-Oriented. Every goal needs a designated time parameter, a deadline to focus on, and something to work toward. Hogston (2011) suggests using the REEPIG standards to ensure that care is of the highest standards. By this means, nursing care plans should be: Realistic. Given available resources. Explicitly stated. Be clear about precisely what must be done, so there is no room for misinterpretation of instructions. Evidence-based. That there is research that supports what is being proposed. Prioritized. The most urgent problems are being dealt with first. Involve. Involve both the patient and other members of the multidisciplinary team who are going to be involved in implementing the care. Goal-centered. That the care planned will meet and achieve the goal set. Goals and expected outcomes must be measurable and client-centered. Goals are constructed by focusing on problem prevention, resolution, and rehabilitation. Goals can be short-term or long-term. Most goals are short-term in an acute care setting since much of the nurse's time is spent on the client's immediate needs. Long-term goals are often used for clients who have chronic health problems or live at home, in nursing homes, or in extended-care facilities. Short-term goal. A statement distinguishing a shift in behavior that can be completed immediately, usually within a few hours or days. Long-term goal. Indicates an objective to be completed over a longer period, usually weeks or months. Discharge planning. Involves naming long-term goals, therefore promoting continued restorative care and problem resolution through home health, physical therapy, or various other referral sources. Goals or desired outcome statements usually have four components: a subject, a verb, conditions or modifiers, and a criterion of desired performance. Components of goals and desired outcomes in a nursing care plan. Subject. The subject is the client, any part of the client, or some attribute of the client (i.e., pulse, temperature, urinary output). That subject is often omitted in writing goals because it is assumed that the subject is the client unless indicated otherwise (family, significant other). Verb. The verb specifies an action the client is to perform, for example, what the client is to do, learn, or experience. Conditions or modifiers. These are the "what, when, where, or how" that are added to the verb to explain the circumstances under which the behavior is to be performed. Criterion of desired performance. The criterion indicates the standard by which a performance is evaluated or the level at which the client will perform the specified behavior. These are optional. When writing goals and desired outcomes, the nurse should follow these tips: Write goals and outcomes in terms of client responses and not as activities of the nurse. Begin each goal with "Client will […]" help focus the goal on client behavior and responses. Avoid writing goals on what the nurse hopes to accomplish, and focus on what the client will do. Use observable, measurable terms for outcomes. Avoid using vague words that require interpretation or judgment of the observer. Desired outcomes should be realistic for the client's resources, capabilities, limitations, and on the designated time span of care. Ensure that goals are compatible with the therapies of other professionals. Ensure that each goal is derived from only one nursing diagnosis. Keeping it this way facilitates evaluation of care by ensuring that planned nursing interventions are clearly related to the diagnosis set. Care plans must be updated continually, not just at admission or discharge. Lastly, make sure that the client considers the goals important and values them to ensure cooperation. Nursing interventions are activities or actions that a nurse performs to achieve client goals. Interventions chosen should focus on eliminating or reducing the etiology of the priority nursing problem or diagnosis. As for risk nursing problems, interventions should focus on reducing the client's risk factors. In this step, nursing interventions are identified and written during the planning step of the nursing process; however, they are actually performed during the implementation step. Nursing interventions can be independent, dependent, or collaborative: Types of nursing interventions in a care plan. Independent nursing interventions are activities that nurses are licensed to initiate based on their sound judgement and skills. Includes: ongoing assessment, emotional support, providing comfort, teaching, physical care, and making referrals to other health care professionals. Dependent nursing interventions are activities carried out under the physician's orders or supervision. Includes orders to direct the nurse to provide medications, intravenous therapy, diagnostic tests, treatments, diet, and activity or rest. Assessment and providing explanation while administering medical orders are also part of the dependent nursing interventions. Collaborative interventions are actions that the nurse carries out in collaboration with other health team members, such as physicians, social workers, dietitians, and therapists. These actions are developed in consultation with other health care professionals to gain their professional viewpoint. Nursing interventions should be: Safe and appropriate for the client's age, health, and condition. Achievable with the resources and time available. Inline with the client's values, culture, and beliefs. Inline with other therapies. Based on nursing knowledge and experience or knowledge from relevant sciences. When writing nursing interventions, follow these tips: Write the date and sign the plan. The date the plan is written is essential for evaluation, review, and future planning. The nurse's signature demonstrates accountability. Nursing interventions should be specific and clearly stated, beginning with an action verb indicating what the nurse is expected to do. Action verb starts the intervention and must be precise. Qualifiers of how, when, where, time, frequency, and amount provide the content of the planned activity. For example: "Educate parents on how to take temperature and notify of any changes," or "Assess urine for color, amount, odor, and turbidity." Use only abbreviations accepted by the institution. When selecting nursing interventions, it's best to draw from published clinical practice guidelines (CPGs) or consensus statements that address the patient's specific diagnosis. For example, if you're caring for someone with heart failure, you might reference American Heart Association guidelines that recommend daily weight checks, a reduced-sodium diet, and careful monitoring of fluid intake. If you're treating a patient with diabetes, check the American Diabetes Association guidelines for interventions such as regular blood glucose testing, foot care routines, and scheduling meals with medication times. Rationales, also known as scientific explanations, explain why the nursing intervention was chosen for the NCP. Sample nursing interventions and rationale for a care plan (NCP) Rationales do not appear in regular care plans. They are included to assist nursing students in associating the pathophysiological and psychological principles with the selected nursing intervention. Evaluation is a planned, ongoing, purposeful activity in which the client's progress towards achieving goals or desired outcomes is assessed, and the effectiveness of the nursing care plan (NCP). Evaluation is an essential aspect of the nursing process because the conclusions drawn from this step determine whether the nursing intervention should be terminated, continued, or changed. The client's care plan is documented according to hospital policy and becomes part of the client's permanent medical record, which may be reviewed by the oncoming nurse. Different nursing programs have different care plan formats. Most are designed so that the student systematically proceeds through the interrelated steps of the nursing process, and many use a five-column format. Nursing Care Plan List This section lists the sample nursing care plans (NCP) and nursing diagnoses for various diseases and health conditions. They are segmented into categories: Miscellaneous nursing care plans examples that don't fit other categories: Care plans that involve surgical intervention. Nursing care plans about the different diseases of the cardiovascular system: Nursing care plans (NCP) related to the endocrine system and metabolism: Care plans (NCP) covering the disorders of the gastrointestinal and digestive system: Care plans related to the hematologic and lymphatic system: NCPs for communicable and infectious diseases: All about disorders and conditions affecting the integumentary system: Nursing care plans about the care of the pregnant mother and her infant. See care plans for maternity and obstetric nursing: Care plans for mental health and psychiatric nursing: Care plans related to the musculoskeletal system: Nursing care plans (NCP) for related to nervous system disorders: Care plans relating to eye disorders: Ophthalmic Care PlansCataractsGlaucomaMacular Degeneration Nursing care plans (NCP) for pediatric conditions and diseases: Care plans related to the reproductive and sexual function disorders: Care plans for respiratory system disorders: Care plans related to the kidney and urinary system disorders: Recommended nursing diagnosis and nursing care plan books and resources. Disclosure: Included below are affiliate links from Amazon at no additional cost from you. We may earn a small commission from your purchase. For more information, check out our privacy policy. Ackley and Ladwig's Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning CareWe love this book because of its evidence-based approach to nursing interventions. This care plan handbook uses an easy, three-step system to guide you through client assessment, nursing diagnosis, and care planning. Includes step-by-step instructions showing how to implement care and evaluate outcomes, and help you build skills in diagnostic reasoning and critical thinking. Nursing Diagnosis Manual: Planning, Individualizing, and Documenting Client Care Identify interventions to plan, individualize, and document care for more than 800 diseases and disorders. Only in the Nursing Diagnosis Manual will you find for each diagnosis subjectively and objectively – sample clinical applications, prioritized action/interventions with rationales – a documentation section, and much more! Recommended reading materials and sources for this NCP guide: Björvell, C., Thorell-Ekstrand, I., & Wredling, R. (2000). Development of an audit instrument for nursing care plans in the patient record. BMJ Quality & Safety, 9(1), 6-13. [Link] DeLaune, S. C., & Ladner, P. K. (2011). 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Yildirim, B., & Ozkahraman, S. (2011). Critical thinking in nursing process and education. International journal of humanities and social science, 1(13), 257-262. FacebookEmailPrintBufferPinterestShare Writing the best nursing care plan requires a step-by-step approach to complete the parts needed for a care plan correctly. This tutorial will walk you through developing a care plan. This guide has the ultimate database and list of nursing care plans (NCP) and nursing diagnosis samples for our student nurses and professional nurses to use—all for free! Care plan components, examples, objectives, and purposes are included with a detailed guide on writing an excellent nursing care plan or a template for your unit. A nursing care plan (NCP) is a formal process that correctly identifies existing needs and recognizes a client's potential needs or risks. Care plans provide a way of communication among nurses, their patients, and other healthcare providers to achieve healthcare outcomes. 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In this step, the nurse can identify the related or risk factors and defining characteristics that can be used to formulate a nursing diagnosis. Some agencies or nursing schools have specific assessment formats you can use. Critical thinking is key in patient assessment, integrating knowledge across sciences and professional guidelines to inform evaluations. This process, crucial for complex clinical decision-making, aims to identify patients' healthcare needs effectively, leveraging a supportive environment and reliable information Now that you have information about the client's health, analyze, cluster, and organize the data to formulate your nursing diagnosis, priorities, and desired outcomes. Nursing diagnoses are a uniform way of identifying, focusing on and dealing with specific client needs and responses to actual and high-risk problems. Actual or potential health problems that can be prevented or resolved by independent nursing intervention are termed nursing diagnoses. 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By this means, nursing care plans should be: Realistic. Given available resources. Explicitly stated. Be clear about precisely what must be done, so there is no room for misinterpretation of instructions. Evidence-based. That there is research that supports what is being proposed. Prioritized. The most urgent problems are being dealt with first. Involve. Involve both the patient and other members of the multidisciplinary team who are going to be involved in implementing the care. Goal-centered. That the care planned will meet and achieve the goal set. Goals and expected outcomes must be measurable and client-centered. Goals are constructed by focusing on problem prevention, resolution, and rehabilitation. Goals can be short-term or long-term. Most goals are short-term in an acute care setting since much of the nurse's time is spent on the client's immediate needs. Long-term goals are often used for clients who have chronic health problems or live at home, in nursing homes, or in extended-care facilities. Short-term goal. A statement distinguishing a shift in behavior that can be completed immediately, usually within a few hours or days. Long-term goal. Indicates an objective to be completed over a longer period, usually weeks or months. Discharge planning. Involves naming long-term goals, therefore promoting continued restorative care and problem resolution through home health, physical therapy, or various other referral sources. Goals or desired outcome statements usually have four components: a subject, a verb, conditions or modifiers, and a criterion of desired performance. Components of goals and desired outcomes in a nursing care plan. Subject. The subject is the client, any part of the client, or some attribute of the client (i.e., pulse, temperature, urinary output). That subject is often omitted in writing goals because it is assumed that the subject is the client unless indicated otherwise (family, significant other). Verb. The verb specifies an action the client is to perform, for example, what the client is to do, learn, or experience. Conditions or modifiers. These are the "what, when, where, or how" that are added to the verb to explain the circumstances under which the behavior is to be performed. Criterion of desired performance. The criterion indicates the standard by which a performance is evaluated or the level at which the client will perform the specified behavior. These are optional. When writing goals and desired outcomes, the nurse should follow these tips: Write goals and outcomes in terms of client responses and not as activities of the nurse. Begin each goal with "Client will […]" help focus the goal on client behavior and responses. Avoid writing goals on what the nurse hopes to accomplish, and focus on what the client will do. Use observable, measurable terms for outcomes. Avoid using vague words that require interpretation or judgment of the observer. Desired outcomes should be realistic for the client's resources, capabilities, limitations, and on the designated time span of care. Ensure that goals are compatible with the therapies of other professionals. Ensure that each goal is derived from only one nursing diagnosis. Keeping it this way facilitates evaluation of care by ensuring that planned nursing interventions are clearly related to the diagnosis set. Care plans must be updated continually, not just at admission or discharge. Lastly, make sure that the client considers the goals important and values them to ensure cooperation. Nursing interventions are activities or actions that a nurse performs to achieve client goals. Interventions chosen should focus on eliminating or reducing the etiology of the priority nursing problem or diagnosis. As for risk nursing problems, interventions should focus on reducing the client's risk factors. In this step, nursing interventions are identified and written during the planning step of the nursing process; however, they are actually performed during the implementation step. Nursing interventions can be independent, dependent, or collaborative: Types of nursing interventions in a care plan. Independent nursing interventions are activities that nurses are licensed to initiate based on their sound judgement and skills. Includes: ongoing assessment, emotional support, providing comfort, teaching, physical care, and making referrals to other health care professionals. Dependent nursing interventions are activities carried out under the physician's orders or supervision. Includes orders to direct the nurse to provide medications, intravenous therapy, diagnostic tests, treatments, diet, and activity or rest. Assessment and providing explanation while administering medical orders are also part of the dependent nursing interventions. Collaborative interventions are actions that the nurse carries out in collaboration with other health team members, such as physicians, social workers, dietitians, and therapists. These actions are developed in consultation with other health care professionals to gain their professional viewpoint. Nursing interventions should be: Safe and appropriate for the client's age, health, and condition. Achievable with the resources and time available. Inline with the client's values, culture, and beliefs. Inline with other therapies. Based on nursing knowledge and experience or knowledge from relevant sciences. When writing nursing interventions, follow these tips: Write the date and sign the plan. The date the plan is written is essential for evaluation, review, and future planning. The nurse's signature demonstrates accountability. Nursing interventions should be specific and clearly stated, beginning with an action verb indicating what the nurse is expected to do. Action verb starts the intervention and must be precise. Qualifiers of how, when, where, time, frequency, and amount provide the content of the planned activity. For example: "Educate parents on how to take temperature and notify of any changes," or "Assess urine for color, amount, odor, and turbidity." Use only abbreviations accepted by the institution. When selecting nursing interventions, it's best to draw from published clinical practice guidelines (CPGs) or consensus statements that address the patient's specific diagnosis. For example, if you're caring for someone with heart failure, you might reference American Heart Association guidelines that recommend daily weight checks, a reduced-sodium diet, and careful monitoring of fluid intake. If you're treating a patient with diabetes, check the American Diabetes Association guidelines for interventions such as regular blood glucose testing, foot care routines, and scheduling meals with medication times. Rationales, also known as scientific explanations, explain why the nursing intervention was chosen for the NCP. Sample nursing interventions and rationale for a care plan (NCP) Rationales do not appear in regular care plans. They are included to assist nursing students in associating the pathophysiological and psychological principles with the selected nursing intervention. Evaluation is a planned, ongoing, purposeful activity in which the client's progress towards achieving goals or desired outcomes is assessed, and the effectiveness of the nursing care plan (NCP). Evaluation is an essential aspect of the nursing process because the conclusions drawn from this step determine whether the nursing intervention should be terminated, continued, or changed. The client's care plan is documented according to hospital policy and becomes part of the client's permanent medical record, which may be reviewed by the oncoming nurse. Different nursing programs have different care plan formats. Most are designed so that the student systematically proceeds through the interrelated steps of the nursing process, and many use a five-column format. Nursing Care Plan List This section lists the sample nursing care plans (NCP) and nursing diagnoses for various diseases and health conditions. They are segmented into categories: Miscellaneous nursing care plans examples that don't fit other categories: Care plans that involve surgical intervention. Nursing care plans about the different diseases of the cardiovascular system: Nursing care plans (NCP) related to the endocrine system and metabolism: Care plans (NCP) covering the disorders of the gastrointestinal and digestive system: Care plans related to the hematologic and lymphatic system: NCPs for communicable and infectious diseases: All about disorders and conditions affecting the integumentary system: Nursing care plans about the care of the pregnant mother and her infant. See care plans for maternity and obstetric nursing: Care plans for mental health and psychiatric nursing: Care plans related to the musculoskeletal system: Nursing care plans (NCP) for related to nervous system disorders: Care plans relating to eye disorders: Ophthalmic Care PlansCataractsGlaucomaMacular Degeneration Nursing care plans (NCP) for pediatric conditions and diseases: Care plans related to the reproductive and sexual function disorders: Care plans for respiratory system disorders: Care plans related to the kidney and urinary system disorders: Recommended nursing diagnosis and nursing care plan books and resources. Disclosure: Included below are affiliate links from Amazon at no additional cost from you. We may earn a small commission from your purchase. For more information, check out our privacy policy. Ackley and Ladwig's Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning CareWe love this book because of its evidence-based approach to nursing interventions. This care plan handbook uses an easy, three-step system to guide you through client assessment, nursing diagnosis, and care planning. Includes step-by-step instructions showing how to implement care and evaluate outcomes, and help you build skills in diagnostic reasoning and critical thinking. Nursing Diagnosis Manual: Planning, Individualizing, and Documenting Client Care Identify interventions to plan, individualize, and document care for more than 800 diseases and disorders. Only in the Nursing Diagnosis Manual will you find for each diagnosis subjectively and objectively – sample clinical applications, prioritized action/interventions with rationales – a documentation section, and much more! Recommended reading materials and sources for this NCP guide: Björvell, C., Thorell-Ekstrand, I., & Wredling, R. (2000). Development of an audit instrument for nursing care plans in the patient record. BMJ Quality & Safety, 9(1), 6-13. [Link] DeLaune, S. C., & Ladner, P. K. (2011). 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Yildirim, B., & Ozkahraman, S. (2011). Critical thinking in nursing process and education. International journal of humanities and social science, 1(13), 257-262. FacebookEmailPrintBufferPinterestShare Nursing care plans are written tools that outline nursing diagnoses, interventions, and goals. Care plans are especially useful for student nurses as they learn to utilize the nursing process. By creating a nursing care plan based on patient data, the nurse learns how to prioritize, plan goals and interventions, and evaluate outcomes related to specific disease processes. Care plans are essential for communication between nurses and other care team members to provide high-quality, continuous, evidence-based care. Nursing care plans are a structured framework for delivering evidence-based patient care. Care plans are often described as the roadmap of patient care2, as they help nurses plan, prioritize, rationalize, and evaluate interventions. Below are some of the benefits of using care plans in nursing practice. 1. Follows the client from admission to discharge.Care plans are continually updated based on the patient's status, goals, and outcomes and follow the patient across facility transfers and care settings. 2. Helps nurses plan interventions and revise care.Care plans provide structure to interventions, allowing the nurse to assess the intervention's outcome and potentially revise care based on the patient's status. 3. Monitoring patient progress.Care plans include a combination of short and long-term goals that are specific, measurable, and timely. The nurse can monitor if interventions are effective by evaluating goal progression. 4. Communication and continuity between nurses.The plan of care is a document that assists nurses in providing continuous and consistent care, working toward shared goals. 5. Coordinates other disciplines.The care plan may include input or interventions provided by other interdisciplinary team members to communicate priorities and enhance collaboration. 6. Engage with the patient/patient-centered care.Whenever possible, the patient should be involved in creating their plan of care. Nursing care plans are best used collaboratively with patients and families to account for a patient's preferences, values, culture, and lifestyle.2 7. Documentation purposes.Care plans are an opportunity for nurses to demonstrate that safe and ethical care was provided in accordance with professional regulations. Documentation may be used for communication, quality improvement, research, or legal proceedings. 8. Offers a framework for consistent care.A nursing diagnosis supports the care plan and outlines appropriate interventions. Nursing diagnoses should align with a NANDA-I approved nursing diagnosis, creating consistency in nursing diagnosis terminology and facilitating effective communication.1 9. Prevents future health hazards.Some care plans may include nursing diagnoses the patient is at risk for, like falls or infection. Care plan interventions and goals can be created to prevent complications. There is some variation in how care plans are used in practice. The structure and format of a care plan depend on the purpose of the care plan and the care setting. Generally, informal care plans are not formally documented. Informal care plans might include the nurse's goals for their shift. These goals can be modified depending on the day's priorities or changes in the patient's condition. Formal care plans are documented as part of the patient record used to coordinate, prioritize, and maintain continuity of care. While formal care plans are also modifiable depending on new priorities or the outcomes of interventions, they are often related to the longer-term goals of the patient. The formal care plan might include goals to meet before discharge from the hospital or the service. Both formal and informal care plans are used within the framework of the nursing process. Care plans can be either standardized or individualized for the patient. Many care settings will use standardized care plans for specific patient conditions to deliver consistent care. One example of a standardized care plan is the post-operative care pathway used in post-surgical units. These post-operative care plans outline expected goals for each post-operative day. However, standardized care plans should be tailored when possible to the needs of the individual patient. In contrast, individualized care plans are created for individual patient needs. Individualized care plans should include input from the patient whenever possible to create personalized goals and support patient adherence. When creating an individualized care plan, consider the patient's health status, history, and motivational factors and inquire about what matters most to them. Care plans enter the nursing process at the planning stage but are influenced by all other steps. The steps of the nursing process can be remembered with the acronym ADPIE.3 Assessment Diagnosis Planning Implementation/Interventions Evaluation Here is a breakdown of the nursing process: 1. Assessment: Assessing the client's needs, gathering dataIn the assessment phase of the nursing process, the nurse collects and analyzes subjective and objective data. Then, the nurse uses their nursing knowledge and critical thinking skills to decide if further assessments are necessary to identify a nursing diagnosis. 2. Diagnosis: What's going on? Crafting a nursing diagnosisBased on data collected during the assessment phase, the nurse crafts a nursing diagnosis that can be used to direct care planning.4 The nurse should assign a nursing diagnosis using the standardized terminology laid out by NANDA-I. A nursing diagnosis is a clinical judgment that describes actual or potential health problems or opportunities for health improvement of a patient, family, or community. 3. Planning: Time to create goalsIn step three of the nursing process, the nurse, ideally in collaboration with the patient, creates goals of care based on the nursing diagnosis. A care plan, including interventions and expected outcomes, is created to achieve these goals. 4. Implementation: Time to actIn the implementation phase of the nursing process, the nurse takes action and performs the interventions described in the care plan to achieve the goals of care. Following evidence-based practice, the nurse uses their knowledge, experience, and critical thinking to decide which interventions are a priority. Often, interventions are based on orders from the physician. 5. Evaluate: What are the outcomes?In the evaluation phase of the nursing process, the nurse reassesses the patient to determine if the intervention has the desired outcome. Next, the nurse should evaluate if the goals of care have been met or require more time. If the intervention does not have the desired effect, the nurse should consider if the care plan needs revision or if the goals of care need to be updated. Here is an example of how the steps of the nursing process fit together. The nurse assesses the client who was in a motor vehicle accident. The client reports a pain level of 9/10 in their right shoulder. Through an x-ray, the client is determined to have a dislocated shoulder, and the nursing diagnosis of acute pain is applied. The nurse begins planning treatment and goals to reduce pain and instill comfort. The nurse administers IV pain medication as ordered and elevates the right arm with pillows. The nurse evaluates the effectiveness of interventions by asking the client to rate their pain on a scale of 0-10. Depending on the outcome, the nurse may determine that the intervention was successful or requires revision. With experience, nursing care plans become second nature as part of nursing practice. Since nursing care planning can be formal or informal, a nursing care plan may look very different depending on the care context and the patient's needs. While informal care plans may not be written in the medical record, writing effective formal care plans takes practice. Formal care plans are important for communicating significant changes in the patient's condition to the care team. Care plans will appear differently depending on each electronic health record, computer platform, setting (home health, doctor's office, etc.), and nursing specialty (case management, PACU, etc.). Regardless, the nursing process remains the same. One way to improve the skill of care plan writing is to read examples of high-quality care plans. Nurses can also ask experienced colleagues for feedback on their care plans. Some care settings will have templates of expected formal care plans. Overall, the care plan should flow seamlessly as part of the nursing process, taking into account relevant nursing diagnoses, expected outcomes, and the effectiveness of the planned interventions. If necessary, goals are revised, and the care plan is repeated until goals are met or are no longer applicable. While rationales are not included in professional nursing care plans, they are common in student care plans. When learning to write care plans, adding the rationale behind the diagnosis and interventions can be helpful. Students can explain the pathophysiology behind their assessment and why an intervention is necessary to guide their understanding. Consider the hierarchy of needs. In any care setting, there are often competing priorities to manage. When deciding on how to prioritize care needs for patients, a useful framework to organize care is Maslow's hierarchy of needs.5 The highest priority needs are at the bottom of the pyramid, including physiological needs such as breathing, nutrition, and sleep. The nurse must prioritize physical needs over those closer to the top of the pyramid, such as the need for a sense of connection. S.M.A.R.T. goals are specific, measurable, attainable, realistic, and time-bound. SMART goals are helpful in care planning because they increase the likelihood that the goal created will be practical and achievable. Conversely, goals that are too vague or not realistic are less likely to be achieved, which can discourage the goal-setter. SpecificSpecific goals are not overly broad. A shared goal of "walking more" is not specific. However, "Walk three laps around the unit three times a day" is specific. MeasurableRelated to being specific, there should be some way to measure whether the goal has been met or is at least progressing. There should be a benchmark that signals that the goal has been met. Benchmarks could be behavioral, physical, or expressed by the patient. AttainableGoals might take work to meet, but attainable goals are within reach. Goals that are too difficult or require multiple steps to reach are more likely to discourage rather than motivate. RealisticAn achievable goal is also realistic. Attainable goals are possible to meet, while realistic goals take into consideration the context and potential barriers to meeting the goal. Time-bound Setting a time limit on the goal grounds the goal in reality and allows for measurement. The chosen period should depend on the goal's size and should support progress and focus. Here are two examples of how SMART goals can be used in care planning: Goal: "The client will rate their pain three or less on a scale of 0-10 by discharge." Specific: The goal includes an exact number on the pain scale acceptable to the patient. Measurable: The goal can be tracked over time and measured on the pain scale. Attainable: This depends on the specific patient context, but for the example, we will assume this is an achievable goal for the patient and medical condition. Realistic: Similarly, this goal must be realistic, which will depend on the patient's pain tolerance. Time-bound: In the inpatient setting, 'by discharge' is an appropriate time frame. Goal: The patient will demonstrate independently using a glucometer to check their blood glucose and how to self-administer insulin after three diabetes education sessions. Specific: The goal includes specific behaviors and outcomes of the education sessions. Measurable: The nurse can assess if the goal is complete by asking the patient to demonstrate their skills. Attainable: The patient has the motor and cognitive ability to learn these skills. Realistic: Enough time has been given for practice and education so that the patient feels comfortable and confident. Time-bound: This goal is set to be achieved after three education sessions. At the end of the third session, the nurse can assess if the goal has been met or if more support or time is needed to meet this goal. When creating goals of care, it can be helpful to categorize goals into short-term or long-term goals. Short-term goals are commonly found in acute care settings, where care interactions are shorter than in the community. However, both long and short-term goals are used across care settings. Short-term goals can be completed within a few hours or days. Although there is no precise cut-off for what makes a short-term care goal, short-term goals tend to focus on issues that need to be immediately addressed. An example of a short-term care goal is to improve the patient's dyspnea by identifying the cause and administering an intervention to relieve the shortness of breath. In contrast, long-term goals are usually completed over weeks or months. Long-term care goals often target chronic health challenges, prevention, and improvement. While important, they may be less urgent than short-term care goals. An example of a long-term care goal is the reduction of HbA1c over several months for a patient at risk for diabetes. Once goals and a plan of care are established, the nurse will perform interventions based on evidence-based practice. There are three main categories of nursing interventions: Independent: Independent nursing interventions are within the nurse's scope of practice and do not require the participation of another health professional, such as a physician, to carry out the intervention. Nurses can initiate, implement, and evaluate independent nursing interventions. An example of an independent nursing intervention is providing patient education. Dependent: Dependent nursing interventions require the participation of another health professional to carry out the intervention. Dependent interventions are often ordered by physicians and then implemented by nurses. Collecting blood work that a physician has ordered is an example of a dependent nursing intervention. Collaborative: Collaborative nursing interventions are carried out with other healthcare professionals through collaboration or consultation. Collaborating with a physical therapist on exercises to improve patient mobility is an example of a collaborative nursing intervention. 1. Create goals with the patient when possible. The patient should be included in their care plan to ensure goals are congruent with their lifestyle, values, and preferences. This requires patient involvement in planning interventions and defining the intervention's successful outcome. Including the patient in the care planning process will increase their motivation to actively participate in their care. 2. Revise goals if necessary. If the goal is not met within the original timeframe, the goal may need revision to ensure that it is achievable and realistic, or the timeframe may need to be extended. 3. Continue to assess and reassess the patient. It is essential to continually evaluate the patient's status to ensure that the goals and interventions are still appropriate. 4. If a goal is not met, assess why. Interventions that are not working or care plan goals that are not met require revision. This may include revising the interventions, updating the goals of care, reviewing the diagnosis, assessing the patient's motivation or lack thereof, and furthering patient education. 5. Ensure progress is recognized even if a goal is not met. In some situations, the goal's timeline may need to be extended for a goal to be met. Consider that a goal may be 'met' even if the outcome is not what was intended. NANDA International. Our Story. Accessed January 7, 2023. Capriotti T, eBook Nursing Collection – Worldwide, Books@Ovid Purchased eBooks. Nursing Care Planning Made Incredibly Easy! Third. Wolters Kluwer; 2018. Toney-Butler T, Thayer J. Nursing Process. Published 2022. Carpenito LJ, Books@Ovid Purchased eBooks. 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