URSING CARE PLAN

Standardized Template | Evidence-B

● PATIENT DEMOGRAPHICS & ADMISSION DATA

Patient Full Name	Date of Birth	Age	Sex / Gender

Medical Record No. (MRN)	Ward / Unit / Bed No.	Admission Date	Discharge Date

Primary Medical Diagnosis	Secondary Diagnoses

Attending Physician	Primary Nurse	Care Plan Initiated

Allergies	Code Status	Isolation Precautions

● INITIAL NURSING ASSESSMENT SUMMARY

BP (mmHg)	HR (bpm)	RR (/min)	Temp (°C)	SpO2 (%)	Pain (0-10)	Weight (kg)	Height (cm)

NEUROLOGICAL

- ■ Alert & Oriented
- ■ Confused/Disoriented
- ■ LOC Changes
- ■ Pain/Headache

RESPIRATORY

- ■ Clear Breath Sounds
- ■ Dyspnea
- ■ Cough
- ■ O2 Required

CARDIOVASCULAR

- ■ Regular Rate/Rhythm
- ■ Edema
- ■ Chest Pain
- ■ Peripheral Pulses Intact

GASTROINTESTINAL

- ■ Normal Bowel Sounds
- ■ Nausea/Vomiting
- ■ Abdominal Pain
- ■ Last BM: _____

GENITOURINARY

- ■ Normal Urine Output
- ■ Dysuria
- ■ Catheter In-situ
- ■ Incontinence

MUSCULOSKELETAL

- ■ Full ROM
- ■ Weakness
- ■ Immobility
- ■ Fall Risk: ____

INTEGUMENTARY

- ■ Skin Intact
- ■ Wound/Ulcer
- ■ Rash
- ■ Wound Site: _____

PSYCHOSOCIAL

- ■ Cooperative
- ■ Anxious/Fearful
- ■ Depressed
- ■ Support System Adequate

ADDITIONAL NOTES / SIGNIFICANT HISTORY

NANDA-I FORMAT REMINDER: [Diagnostic Label] **related to** [Etiology/Related Factors] **as evidenced by** [Defining Characteristics / Signs & Symptoms]

NURSING CARE PLAN #1

Domain: ________________________________ Class: ___________________________

■ HIGH PRIORITY | ■ MEDIUM PRIORITY | ■ LOW PRIORITY | ■ RISK DIAGNOSIS | ■ HEALTH PROMOTION

Common NANDA Diagnoses: Acute Pain | Impaired Gas Exchange | Risk for Infection | Deficient Fluid Volume | Activity Intolerance

① STEP 1 — NURSING DIAGNOSIS (NANDA-I)

NANDA-I NURSING DIAGNOSIS STATEMENT

DIAGNOSTIC LABEL (Problem)	RELATED FACTORS (Etiology)	DEFINING CHARACTERISTICS (S&S;)

As evidenced by:

② STEP 2 — EXPECTED OUTCOMES / GOALS (NOC)

#	OUTCOME / GOAL (SMART)	TARGET DATE / TIMEFRAME
1		
2		
3		
4		

NOC Reference: Functional Health ■ Physiologic Health ■ Psychosocial Health ■ Health Knowledge ■ Perceived Health ■

③ STEP 3 — NURSING INTERVENTIONS (NIC)

#	NIC CATEGORY	NURSING INTERVENTION / RATIONALE	FREQUENCY / RESPONSIBLE
1	Assessment		
2	Assessment		
3	Independent		
4	Independent		
5	Collaborative		
6	Collaborative		
7	Education		
8	Education		

■ Assessment ■ Independent ■ Collaborative ■ Education/Teaching

④ STEP 4 — EVALUATION & REASSESSMENT

DATE / TIME	EVALUATION OF OUTCOME ACHIEVEMENT	STATUS	NURSE SIGNATURE
		■ Goal Met ■ Partially Met ■ Not Met ■ Ongoing ■ Revised	
		■ Goal Met ■ Partially Met ■ Not Met ■ Ongoing ■ Revised	
		■ Goal Met ■ Partially Met ■ Not Met ■ Ongoing	

PLAN REVISED ON: _______________ **REASON FOR REVISION:** ____
REVISED BY: ___________________

NURSING CARE PLAN #2

Domain: ________________________________ Class: ____________________________

■ HIGH PRIORITY | ■ MEDIUM PRIORITY | ■ LOW PRIORITY | ■ RISK DIAGNOSIS | ■ HEALTH PROMOTION

Common NANDA Diagnoses: Anxiety | Ineffective Coping | Disturbed Sleep Pattern | Deficient Knowledge | Fear

① STEP 1 — NURSING DIAGNOSIS (NANDA-I)

NANDA-I NURSING DIAGNOSIS STATEMENT

DIAGNOSTIC LABEL (Problem)	RELATED FACTORS (Etiology)	DEFINING CHARACTERISTICS (S&S;)

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PLAN REVISED ON: _______________ **REASON FOR REVISION:** ____
REVISED BY: ___________________

NURSING CARE PLAN #3

Domain: ______________________________ Class: ______________________________

■ HIGH PRIORITY | ■ MEDIUM PRIORITY | ■ LOW PRIORITY | ■ RISK DIAGNOSIS | ■ HEALTH PROMOTION

Common NANDA Diagnoses: Impaired Skin Integrity | Risk for Falls | Impaired Physical Mobility | Constipation | Imbalanced Nutrition: Less Than Body Requirements

① STEP 1 — NURSING DIAGNOSIS (NANDA-I)

NANDA-I NURSING DIAGNOSIS STATEMENT

DIAGNOSTIC LABEL (Problem)	RELATED FACTORS (Etiology)	DEFINING CHARACTERISTICS (S&S;)

As evidenced by:

② STEP 2 — EXPECTED OUTCOMES / GOALS (NOC)

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■ Assessment | ■ Independent | ■ Collaborative | ■ Education/Teaching

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PLAN REVISED ON: _______________ **REASON FOR REVISION:** ____
REVISED BY: ___________________

★ NANDA-I QUICK REFERENCE GUIDE

DOMAIN	NAME	COMMON NURSING DIAGNOSES
Domain 1	**Health Promotion**	Deficient community health, Ineffective health maintenance, Readiness for enhanced health management
Domain 2	**Nutrition**	Imbalanced nutrition: less/more than body requirements, Impaired swallowing, Risk for unstable blood glucose
Domain 3	**Elimination/Exchange**	Constipation, Diarrhea, Urinary retention, Impaired gas exchange, Ineffective airway clearance
Domain 4	**Activity/Rest**	Activity intolerance, Fatigue, Impaired physical mobility, Disturbed sleep pattern, Ineffective breathing pattern
Domain 5	**Perception/Cognition**	Acute/Chronic confusion, Impaired memory, Deficient knowledge, Impaired verbal communication
Domain 6	**Self-Perception**	Chronic low self-esteem, Disturbed body image, Hopelessness, Risk for self-directed violence
Domain 7	**Role Relationships**	Caregiver role strain, Impaired parenting, Interrupted family processes, Social isolation
Domain 8	**Sexuality**	Sexual dysfunction, Ineffective relationship, Risk for disturbed maternal-fetal dyad
Domain 9	**Coping/Stress Tolerance**	Anxiety, Ineffective coping, Post-trauma syndrome, Grieving, Death anxiety, Fear
Domain 10	**Life Principles**	Decisional conflict, Impaired religiosity, Moral distress, Readiness for enhanced spiritual well-being
Domain 11	**Safety/Protection**	Risk for infection, Impaired skin integrity, Risk for falls, Risk for injury, Hyperthermia, Hypothermia
Domain 12	**Comfort**	Acute/Chronic pain, Nausea, Impaired comfort, Social isolation
Domain 13	**Growth/Development**	Delayed growth and development, Risk for disproportionate growth, Failure to thrive

✎ CARE PLAN WRITING TIPS & STANDARDS

NANDA-I Diagnosis	Always use the three-part PES format: Problem + Etiology (related to) + Signs/Symptoms (as evidenced by). Use exact NANDA-I language for diagnostic labels.
SMART Goals (NOC)	Goals must be Specific, Measurable, Achievable, Realistic, and Time-bound. State the patient as the subject. Use observable, measurable verbs (demonstrate, maintain, report, ambulate).
NIC Interventions	Include Assessment, Independent, Collaborative, and Teaching interventions. Always provide a scientific rationale for each intervention.
Evaluation	Compare patient response against stated goals. Document Met / Partially Met / Not Met. Revise plan as needed based on ongoing assessment findings.
Documentation	Sign and date every entry. Use approved abbreviations only. Maintain confidentiality per HIPAA/facility policy.

This template is based on NANDA International (NANDA-I) Nursing Diagnoses: Definitions & Classification, NIC (Nursing Interventions Classification), and NOC (Nursing Outcomes Classification). Always cross-reference with current clinical evidence and institutional policies.