PROFESSIONAL NURSING

Care Plan Templates

A Complete Clinical Documentation Toolkit

5 Professional Templates · NANDA-I Aligned · Ready to Print

01	**Basic Care Plan** *Ideal for nursing students and general wards*
02	**NANDA-I Structured Plan** *Full taxonomy-aligned diagnostic template*
03	**Critical Care / ICU Plan** *Detailed monitoring and intervention grid*
04	**Pediatric Care Plan** *Child-focused assessments and family care*
05	**Mental Health Care Plan** *Psychosocial, behavioral, and safety tools*

These templates comply with NANDA International taxonomy and are designed for use in clinical, educational, and training environments. Always adapt to your institution's policies.

01

Basic Nursing Care Plan

General purpose template suitable for all clinical settings and nursing students

PATIENT INFORMATION

Patient Name:		Date of Birth:	
Medical Record #:		Admission Date:	
Attending Physician:		Primary Diagnosis:	
Ward / Unit:		Nurse Name:	

NURSING ASSESSMENT

Subjective Data (Patient Reports)	Objective Data (Nurse Observes)

CARE PLAN

Nursing Diagnosis (PES Format)				

Nurse Signature:		**Date :**		**Time :**		**Supervisor Review:**	

02 NANDA-I Structured Nursing Care Plan

Full taxonomy-aligned template for precise clinical documentation

PATIENT INFORMATION

Patient Name:		**Date of Birth:**	
Medical Record #:		**Admission Date:**	
Attending Physician:		**Primary Diagnosis:**	
Ward / Unit:		**Nurse Name:**	
Allergies:		**Code Status:**	

NANDA-I NURSING DIAGNOSIS

Diagnosis Label:		**Domain:**	
Related To (Etiology):		**Class:**	
As Evidenced By (AEB):		**Diagnosis Type:**	[ ] Actual [ ] Risk [ ] Health Promo [ ] Syndrome

PATIENT OUTCOMES (NOC-ALIGNED)

Short-Term Goal (within 24–48 hrs)	**Long-Term Goal (by discharge)**
Measurable Indicators	**Baseline Score / Target Score**

NURSING INTERVENTIONS (NIC-ALIGNED)

Priority				
[ ] High [ ] Med [ ] Low				

[ ] High [ ] Med [ ] Low				
[ ] High [ ] Med [ ] Low				
[ ] High [ ] Med [ ] Low				
[ ] High [ ] Med [ ] Low				
[ ] High [ ] Med [ ] Low				

EVALUATION

Date/Time	Goal Met?	Evaluation Notes	Plan
	[ ] Met [ ] Partial [ ] Not Met		[ ] Continue [ ] Modify [ ] Discontinue
	[ ] Met [ ] Partial [ ] Not Met		[ ] Continue [ ] Modify [ ] Discontinue

03

Critical Care / ICU Nursing Care Plan

Comprehensive monitoring and intervention documentation for high-acuity patients

PATIENT INFORMATION

Patient Name:		**Date of Birth:**	
Medical Record #:		**Admission Date:**	
Attending Physician:		**Primary Diagnosis:**	
Ward / Unit:		**Nurse Name:**	
ICU Bed #:		**Ventilator:**	
Isolation Type:		**Code Status:**	

HEMODYNAMIC & VITAL SIGNS MONITORING

Parameter	Normal Range	0600	0800	1000	1200	1400	1600	1800	2000
BP (mmHg)	90-120/60-80								
HR (bpm)	60-100								
RR (breaths/min)	12-20								
SpO2 (%)	>95%								
Temp (°C)	36.1-37.2								
MAP (mmHg)	70-100								
CVP (mmHg)	2-8								
Urine Output (mL/hr)	>0.5 mL/kg/hr								

PRIORITY NURSING DIAGNOSES

#				
1				[ ] Met [ ] Partial [ ] Not Met
2				[ ] Met [ ] Partial [ ] Not Met

3				[ ] Met [ ] Partial [ ] Not Met
4				[ ] Met [ ] Partial [ ] Not Met

LINES, DRIPS & INFUSIONS

Line / Device					

NURSE NARRATIVE NOTES

04

Pediatric Nursing Care Plan

Child-focused assessments with developmental considerations and family-centered care

PATIENT & FAMILY INFORMATION

Child's Name:		**Date of Birth:**		**Age:**	
Parent / Guardian:		**MRN:**		**Admission Date:**	
Primary Diagnosis:		**Weight (kg):**		**Height (cm):**	
Immunization Status:		**Allergies:**		**School Grade:**	

PEDIATRIC PAIN ASSESSMENT

Scale Used				
[ ] FLACC [ ] Wong-Baker [ ] Numeric [ ] CRIES	/ 10	/ 10	[ ] Distraction [ ] Positioning [ ] Heat/Cold [ ] Parent presence	

DEVELOPMENTAL & SAFETY ASSESSMENT

Assessment Area			
Developmental milestones	[ ] Met [ ] Delayed		
Fall risk (Humpty-Dumpty scale)	[ ] Met [ ] Delayed		
Skin integrity	[ ] Met [ ] Delayed		
Nutritional status	[ ] Met [ ] Delayed		
Fluid balance	[ ] Met [ ] Delayed		

FAMILY / CAREGIVER EDUCATION

Topic				
Medication administration	[ ] Verbal [ ] Demo [ ] Written	[ ] Parent [ ] Guardian [ ] Child	[ ] Verbalized [ ] Demonstrated	[ ] Yes [ ] N/A
Wound care / dressing change	[ ] Verbal [ ] Demo [ ] Written	[ ] Parent [ ] Guardian [ ] Child	[ ] Verbalized [ ] Demonstrated	[ ] Yes [ ] N/A
Signs of deterioration	[ ] Verbal [ ] Demo [ ] Written	[ ] Parent [ ] Guardian [ ] Child	[ ] Verbalized [ ] Demonstrated	[ ] Yes [ ] N/A
Follow-up appointments	[ ] Verbal [ ] Demo [ ] Written	[ ] Parent [ ] Guardian [ ] Child	[ ] Verbalized [ ] Demonstrated	[ ] Yes [ ] N/A

05 Mental Health Nursing Care Plan

Psychosocial, behavioral, and safety documentation for psychiatric nursing

PATIENT INFORMATION

Patient Name:		**Date of Birth:**	
Medical Record #:		**Admission Date:**	
Attending Physician:		**Primary Diagnosis:**	
Ward / Unit:		**Nurse Name:**	
Legal Status:		**Voluntary / Involuntary:**	
Psychiatrist:		**Clinical Setting:**	

SAFETY & RISK ASSESSMENT

Risk Factor	
Suicidal Ideation	[ ] None [ ] Passive [ ] Active with plan [ ] Active with intent
Self-Harm	[ ] None [ ] History [ ] Current urges [ ] Current behavior
Homicidal Ideation	[ ] None [ ] Passive [ ] Active [ ] Named target
Aggression / Violence	[ ] None [ ] Verbal [ ] Physical [ ] History of violence
Substance Use	[ ] None [ ] Alcohol [ ] Drugs [ ] Current intoxication
Elopement Risk	[ ] Low [ ] Moderate [ ] High

MENTAL STATUS EXAMINATION (MSE)

Domain	
Appearance / Behavior	[ ] Appropriate [ ] Disheveled [ ] Agitated [ ] Withdrawn
Speech	[ ] Normal [ ] Pressured [ ] Slowed [ ] Loud [ ] Soft
Mood (patient states)	
Affect	[ ] Congruent [ ] Flat [ ] Blunted [ ] Labile [ ] Expansive
Thought Process	[ ] Logical [ ] Tangential [ ] Circumstantial [ ] Flight of ideas
Thought Content	[ ] No delusions [ ] Paranoid [ ] Grandiose [ ] Somatic
Perceptions	[ ] No hallucinations [ ] Auditory [ ] Visual [ ] Other
Cognition / Insight	[ ] Intact [ ] Impaired [ ] Limited insight [ ] Good insight

PSYCHOSOCIAL CARE PLAN

Nursing Diagnosis			
Risk for Suicide r/t hopelessness			[ ] Met [ ] Partial [ ] Not Met [ ] Ongoing
Ineffective Coping r/t coping skill deficit			[ ] Met [ ] Partial [ ] Not Met [ ] Ongoing
Disturbed Thought Process r/t psychosis			[ ] Met [ ] Partial [ ] Not Met [ ] Ongoing

THERAPEUTIC COMMUNICATION & MILIEU NOTES

DISCHARGE PLANNING & SAFETY CONTRACT

Discharge Criteria Met:	[ ] Yes [ ] Partially [ ] No	**Target Discharge Date:**	
Follow-up Appointment:		**Crisis Line Provided:**	[ ] Yes [ ] No
Safety Plan in Place:	[ ] Yes [ ] No [ ] Declined	**Medications Dispensed:**	[ ] Yes [ ] No

Nurse Signature:		**Credentials:**		**Date:**		**Time:**	