Nursing Care Plans: Format and Worked Examples

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A nursing care plan sets out the person's assessed needs, priority nursing problems, measurable goals, planned actions and evaluation. Use the blank format below to organise an assignment, then compare the worked examples for pneumonia, heart failure, type 2 diabetes and fall prevention.

If you are unsure where to begin, review ADPIE: the five-step nursing process. For the assessment stage, use the head-to-toe assessment guide; for US exam practice, explore NGN clinical judgment.

Academic and clinical review pending. These original nursing care-plan examples support student learning, not patient-specific prescriptions or independent clinical decisions. Verify diagnostic terminology using your programme's approved references and follow local practice requirements.

Preparing for the US nursing licensure exam? See our 2026 NCLEX-RN preparation guide for the current test plan, NGN clinical judgment, a study plan and original explained questions. These case examples remain separate from official NCLEX exam materials.

Related nursing study guide: For the scientific foundations of nursing care planning, review how body systems support nursing assessment.

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Explore care plans by patient need

Respiratory care

Pneumonia Nursing Care Plan: Assessment, Goals & Rationales

This original adult pneumonia nursing care plan demonstrates how to move from respiratory assessment cues to priority problems, individualised outcomes, interventions with clinical rationales and evaluation. It is a teaching example, not a standing treatment protocol.

Read care plan and rationales ->

Cardiac care

Heart Failure Nursing Care Plan: Symptoms, Goals & Rationales

This heart failure nursing care plan uses an adult case to explain fluid-related symptoms, symptom surveillance, medication safety, shared goals and discharge planning. It distinguishes nursing observation from specialist treatment decisions and avoids blanket fluid or sodium restrictions.

Read care plan and rationales ->

Endocrine care

Type 2 Diabetes Nursing Care Plan: Goals, Safety & Education

This type 2 diabetes nursing care plan shows how assessment can identify self-management gaps, glucose-related risks and person-centred learning goals. It covers prescribed monitoring, hypoglycaemia awareness, foot-health education and evaluation without setting universal targets or changing medication orders.

Read care plan and rationales ->

Patient safety

Fall Prevention Nursing Care Plan: Assessment & Goals

A fall prevention nursing care plan identifies modifiable factors, preserves dignity and promotes safe mobility. This example follows NICE NG249's emphasis on comprehensive, individualised assessment in older people, not reliance on a score to predict falls.

Read care plan and rationales ->

How to write a nursing care plan: the practical sequence

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- Collect usable assessment cues. Record patient-reported symptoms alongside actual measurements, functional limitations, background, environmental needs and safety concerns. Separate known facts from assumptions.
- Cluster cues and prioritise needs. Ask which human response or risk requires nursing attention, which findings are urgent and which can be addressed in collaboration. A medical diagnosis alone is not a nursing care plan.
- Choose appropriate nursing-problem language. Use your school or employer's approved terminology, verify the diagnosis against patient assessment, and cite the edition of the classification you use.
- Agree measurable outcomes. Name the behaviour or response to assess, the individual baseline, relevant target and time frame. For example, assess whether a patient can explain their personal discharge symptom action plan rather than "patient understands."
- Select interventions and write rationales. Connect actions to actual needs and cite applicable clinical standards. Distinguish what a nurse can do independently from actions that require prescriptions, referrals or training.
- Evaluate and revise. Record actual results and barriers. A care plan is not completed when actions are written down; reassess the response and adjust the plan with the team and person.

Nursing care plan format: student-friendly table

Part	Question to answer	Quality test
Assessment	What is happening to this person?	Subjective and objective evidence distinguished
Problem	Which nursing need is important now?	Grounded in observed cues
Goals	What measurable change do we expect?	Specific, realistic, individualised timeframe
Intervention	What action is appropriate and within scope?	Directly connected to problem and plan
Rationale	Why should it help or reduce risk?	Evidence-based explanation
Evaluation	What changed?	Actual evidence, not assumption

Worked example: write an outcome you can evaluate

A fictional, clinically stable patient needs help transferring to the toilet and says, "I do not want to bother anyone." The assessment supports a plan for accessible assistance and safe mobility. Discuss the person's concern before choosing an intervention.

TABLE / One care-plan goal, three possible evaluation findings

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Stage	Example
Goal	Before the next planned transfer, the patient will demonstrate using the call bell and explain the agreed assistance needed.
Intervention and rationale	Place the call bell within reach, test it with the patient and explain how staff will help. Practising the action reveals barriers that verbal instructions alone can miss.
Goal met	The patient demonstrates calling and describes the agreed help. Record what was demonstrated and when; continue reassessing mobility.
Partly met	The patient explains the plan but cannot reach the bell. Reposition it, check accessibility and reassess.
Not met	The patient remains unsure how to request help. Explore hearing, language, cognition or equipment barriers and revise the approach.

"Teaching completed" records an action. The patient's demonstrated response provides evidence for evaluation. For an acute change in breathing or consciousness, prioritise urgent assessment and escalation; do not wait for a routine goal-review time. Use the falls care plan for a fuller example.

What makes a trustworthy care plan?

Plans must be original, clinically grounded, linked to current sources and adjusted for different patients. A person with chronic hypercapnic respiratory failure, for example, may have an individual oxygen target that differs from a generic textbook example. Likewise, routine sodium or fluid restriction is not appropriate for every person with heart failure. Our cases provide clinical reasoning rather than medication doses or procedural instructions.

Free blank nursing care plan worksheet: copy this format

This original worksheet is an educational planning aid. It is not a clinical order or a substitute for approved nursing documentation systems. Use anonymous fictional details when practising online.

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TABLE / Blank student nursing care plan with five core stages

Assessment findings	Priority nursing concern	Measurable outcome and timeframe	Intervention and evidence-based rationale	Evaluation / revise
[Subjective and objective findings, baseline and red flags]	[Human response or risk; reason for priority]	[Personalised target and review time]	[Safe authorised step, specific rationale, guideline]	[Actual response, time, escalation or revision]

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Student task: Copy the table into a Word document, complete it using a fictional patient case, and compare your rationale with the official guidance cited in each condition-specific plan. Use the table above as a copyable worksheet and record a review time beside each goal.

Before handing in a care plan

- Have you separated patient statements from measured observations?
- Have you prioritised urgent deterioration over documentation?
- Can someone else measure the outcome you wrote?
- Does each proposed intervention have a clear, checkable rationale?
- Have you recorded actual findings during evaluation rather than assumed improvement?

Evidence and terminology: Adapt the structure to your programme’s assessment rubric and applicable local professional standards. Consult your approved nursing diagnosis reference and the NMC Code for relevant documentation and scope-of-practice principles.

Frequently asked questions

Can I use the same care plan for every patient with a condition?

No. The condition may suggest common concerns, but assessment, goals and actions must reflect the individual person, setting and current care plan.

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What are rationales in a care plan?

Rationales explain how an action relates to the patient’s needs, physiology, evidence or safety concerns. They should be specific, not generic claims that an action is "best practice."

Which terminology should I use for nursing diagnoses?

Use the current approved terminology required by your nursing programme or clinical institution, and verify the correct diagnosis against the person’s assessment. Cite the classification source in your references.

How this resource is prepared: See our editorial standards, source policy and clinical-review disclosures. References and independent clinical sign-off are not interchangeable.

References and related resources

- Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2024). NANDA International Nursing Diagnoses: Definitions and Classification, 2024-2026 (13th ed.). Thieme. Official publication.

- Clinical Procedures learning library
- Practice Mode (separate question bank)

Scope: These are adult nursing educational examples; paediatric, maternity, critical-care and local-jurisdiction guidance may differ. Faizan’s editorial review is pending and is not represented as professional clinical accreditation.

Source: https://mynursinghub.com/nursing-care-plans/

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