Nursing Diagnosis	Patient Goals	Intervention: Rationale	Implementation (Yes or No)	Evaluation Outcome

EXAMPLE:

Nursing Diagnosis	Patient Goals	Intervention: Rationale	Implementation (Yes or No)	Evaluation Outcome
Diagnosis: High risk for falls related to confusion as evidenced by disorientation to place, time, situation, unsteady gait, generalized weakness *Subjective Data:* Patient asking, "who are you again?" Multiple family stated, "he doesn't seem right" Patient stated, "I feel weak when I get up" *Objective Data:* History of dementia Set off bed alarm continually during night Requires walker for ambulation	Patient will remain free from injury during this admission. Patient will remain free from falls during this admission.	Patient will wear non-skid socks when out of bed: to provide stability during ambulation Patient's bed alarm will be on at all times: to alert staff if patient is attempting to get out of bed independently Patient will be relocated to a room closer to the RN station: to enable staff to visualize patient on a more frequent basis Nurse will increase frequency of rounding: to assess needs more frequently, toilet more often, reorient.	Yes Yes No Yes	Patient utilized non-skid socks during all periods of ambulation, did need to be continually reminded, as he does not like socks, per his report. Will continue to promote. Patient's bed alarm was on consistently throughout shift and patient did set alarm off approximately 4-6 times. Will continue to have bed alarm on. Another confused patient occupied the room closest to RN station; will move if room becomes available. Patient rounded on q 30 min or q 1 hour. Noted that patient became agitated when he had to use the bathroom during first rounding, therefore offered toileting with each visit and noted decrease in agitation. Will continue to round frequently. Patient remained injury and fall free during this shift. Goals progressing.