4.8: Evaluation

*Evaluation* is the sixth step of the nursing process (and the sixth Standard of Practice set by the American Nurses Association). This standard is defined as, “The registered nurse evaluates progress toward attainment of goals and outcomes.”\(^{[1]}\) Both the patient status and the effectiveness of the nursing care must be continuously evaluated and the care plan modified as needed.\(^{[2]}\)

Evaluation focuses on the effectiveness of the nursing interventions by reviewing the expected outcomes to determine if they were met by the time frames indicated. During the evaluation phase, nurses use critical thinking to analyze reassessment data and determine if a patient’s expected outcomes have been met, partially met, or not met by the time frames established. If outcomes are not met or only partially met by the time frame indicated, the care plan should be revised. Reassessment should occur every time the nurse interacts with a patient, discusses the care plan with others on the interprofessional team, or reviews updated laboratory or diagnostic test results. Nursing care plans should be updated as higher priority goals emerge. The results of the evaluation must be documented in the patient’s medical record.

Ideally, when the planned interventions are implemented, the patient will respond positively and the expected outcomes are achieved. However, when interventions do not assist in progressing the patient toward the expected outcomes, the nursing care plan must be revised to more effectively address the needs of the patient. These questions can be used as a guide when revising the nursing care plan:

- Did anything unanticipated occur?
- Has the patient’s condition changed?
- Were the expected outcomes and their time frames realistic?
- Are the nursing diagnoses accurate for this patient at this time?
• Are the planned interventions appropriately focused on supporting outcome attainment?
• What barriers were experienced as interventions were implemented?
• Does ongoing assessment data indicate the need to revise diagnoses, outcome criteria, planned interventions, or implementation strategies?
• Are different interventions required?

Putting It Together

Refer to Scenario C in the "Assessment" section of this chapter and Appendix C. The nurse evaluates the patient's progress toward achieving the expected outcomes.

For the nursing diagnosis Fluid Volume Excess, the nurse evaluated the four expected outcomes to determine if they were met during the time frames indicated:

1. The patient will report decreased dyspnea within the next 8 hours.
2. The patient will have clear lung sounds within the next 24 hours.
3. The patient will have decreased edema within the next 24 hours.
4. The patient’s weight will return to baseline by discharge.

Evaluation of the patient condition on Day 1 included the following data: “The patient reported decreased shortness of breath, and there were no longer crackles in the lower bases of the lungs. Weight decreased by 1 kg, but 2+ edema continued in ankles and calves.” Based on this data, the nurse evaluated the expected outcomes as “Partially Met” and revised the care plan with two new interventions:

1. Request prescription for TED hose from provider.
2. Elevate patient’s legs when sitting in chair.

For the second nursing diagnosis, Risk for Falls, the nurse evaluated the outcome criteria as “Met” based on the evaluation, “The patient verbalizes understanding and is appropriately calling for assistance when getting out of bed. No falls have occurred."

The nurse will continue to reassess the patient’s progress according to the care plan during hospitalization and make revisions to the care plan as needed. Evaluation of the care plan is documented in the patient’s medical record.