4.10: Evaluation

The *Evaluation* Standard of Practice by the American Nurses Association states, “The registered nurse evaluates progress toward attainment of goals and outcomes.”[1] Review the competencies for the *Evaluation* Standard of Practice for registered nurses in the following box.

**ANA’s Evaluation Competencies** [2]

The registered nurse:

- Uses applicable standards and defined criteria (e.g., Quality and Safety Education for Nurses [QSEN], Quadruple Aim, Institute for Healthcare Improvement [IHI]).
- Conducts a systematic, ongoing, and criterion-based evaluation of the goals and outcomes in relation to the structure, processes, and timelines prescribed in the plan.
- Collaborates with the health care consumer, stakeholders, interprofessional team, and others involved in the care or situation in the evaluation process.
- Determines, in partnership with the health care consumer and other stakeholders, the person-centeredness, effectiveness, efficiency, safety, timeliness, and equitability of the strategies in relation to the responses to the plan and attainment of outcomes.
- Uses ongoing assessment data, other data and information resources and benchmarks, research, and meta-analyses for the analytic activities to revise the diagnoses, outcomes, plan, implementation, and evaluation strategies as needed.
- Documents the results of the evaluation.
- Reports evaluation data in a timely fashion.
- Shares evaluation data and conclusions with the health care consumer and other stakeholders to promote clarity and transparency in accordance with state, federal, organizational, and professional requirements.
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. Evaluation includes analysis of data from assessments, screening tools, laboratory results, and pharmacologic interventions, as well as the effectiveness of nursing interventions related to thought process and content. 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. If revision is necessary, the nurse should consider which step of the nursing process requires modification. Have additional assessment data been obtained, or have assessment data changed? Has a different nursing diagnosis become a priority? Were the identified goals or expected outcomes unrealistic? Were any interventions not effective?

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?
- Have the patient’s goals and priorities shifted?
- 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?
- Do ongoing assessment data indicate the need to revise diagnoses, outcome criteria, planned interventions, or implementation strategies?
- Are different interventions required?