FREE STUDY WORKBOOK

Nursing care plans & clinical reasoning

Four fully worked fictional care-plan examples

ADPIE · Clinical judgment · Printable worksheets

01 Assessment & ADPIE

02 Pain, breathing, skin & mobility

03 Answers, evaluation & blank forms

2026 · Original teaching material · nandabase.com

How to use this workbook

A practical method for U.S. nursing students

This workbook teaches how to turn assessment cues into a justifiable educational care plan. The four cases are entirely invented. They are not clinical records, physician orders, official NANDA-I definitions or NCLEX exam questions.

The repeatable four-step study method

- Read: identify facts actually given in the scenario. Quote patient reports accurately.
- Question: list missing baseline, safety context and competing interpretations.
- Plan: state a measurable, person-centered educational goal, then explain what activities would help collect evidence or support that goal within a supervised plan.
- Evaluate: compare a later observation only when one is supplied. Otherwise state “not yet evaluated.”

Worked case versus template: Read a finished example first, then hide its answer and use the blank worksheet at the end. Keep observed facts, provisional concerns, actions and outcomes in separate fields.

What this workbook does not do

It does not assign a diagnosis or recommend treatment to a real patient. For official diagnosis wording and codes, use a currently authorized NANDA-I source. For actual care, follow clinical assessment, professional supervision, employer policy and individual orders.

ADPIE and clinical judgment

Two related ways of organizing a nursing student’s reasoning

A — Assessment

What is known? Record subjective reports, observed data, trend and context; distinguish absent data from a negative finding.

D — Diagnosis / concern

What human response or risk does the evidence suggest? Is more assessment needed? Do not equate a medical disease with a nursing diagnosis.

P — Planning

What change matters to the person? Define a measurable outcome and proposed activities with a clear rationale.

I — Implementation

In real practice, authorized nurses and teams follow individualized orders and policies. A classroom case may describe a hypothetical completed action.

E — Evaluation

What was actually observed afterward? Did it meet the goal, partly meet it, or remain unmeasured? What would change in the plan?

NCLEX clinical judgment: The NCSBN model frames thinking as recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action and evaluate outcomes. It is not a shortcut to a single memorized NANDA label.

Complete care plan: self-care

A fictional example showing every essential element

A fictional adult preparing for discharge says: “I need help dressing in the morning; before admission I did it alone.” The scenario does not supply the current safe assistance level, therapy assessment or home context.

Assessment

Subjective cue: the direct report above. Objective assessment: not supplied. Clarify which dressing tasks are difficult, baseline function, fatigue, pain, home resources and the current plan.

Nursing concern

Possible functional self-care limitation affecting a valued morning routine. Formal terminology would require a complete assessment and authorized reference.

Expected outcome

For classroom purposes: at the next scheduled fictional review, document one agreed dressing step, whether it was completed and the authorized assistance level.

Planned activities and rationale

Clarify baseline and patient priorities; verify team guidance; document observed task performance; coordinate with the relevant care team. These connect the goal with reliable evidence and safe supervision.

Fictional follow-up

During a simulated observation, the person completes one dressing step with a verbal prompt.

Evaluation

The narrow step-specific goal may be met under the described conditions, but broader independence cannot be claimed. The plan needs further function-specific observation.

Write outcomes you can evaluate

Avoid confusing goals with tasks

Weak: “The patient will feel better.”

Better: “At the agreed teaching-case review, record the person’s symptom report and whether a defined task was completed under comparable conditions.”

Weak: “Explain wound prevention.”

Better: “In a simulated teach-back, the learner describes two points from the approved education plan; the student documents which was understood and what needs review.”

Weak: “Skin integrity improves.”

Better: “At a named follow-up, compare documented skin observations with the initial description using the same approved method.”

Intervention: assess, document, communicate, educate or support within an authorized plan. Outcome: what the person reports, demonstrates or what is observed in a specified time and setting.

Evaluation rule: A stated outcome is only achieved if a later observation provides evidence. If the case provides no follow-up, write “not yet evaluated,” not “improved.”

Acute pain: care-plan example

From cues to evaluation — fictional educational example

A fictional post-procedure patient reports soreness with movement (6/10) and discomfort at rest (3/10). The person pauses before standing. There is no information about permitted activity or the existing pain plan.

Known findings

Patient report with two context-specific ratings and an observed pause.

Missing findings

Timing, character, prior function, activity restrictions and assessment of unexpected changes.

Reasoned concern

Discomfort may limit a goal-related activity; it does not automatically validate a licensed diagnosis.

Classroom goal

At a planned simulated review, record the same self-report rating and whether one approved sit-to-stand task was attempted with authorized help.

Activities and rationale

Document self-report, ask about function, check the plan with the team and communicate important changes; these establish baseline and support safe follow-up.

Fictional follow-up

The person reports 4/10 with the same activity and completes one assisted attempt. This does not prove the cause of change.

Evaluation

Compare both measures with the person’s goal. The care plan remains individualized and is revised if the goal is only partly met.

Respiratory concern: care-plan example

From cues to evaluation — fictional educational example

A fictional patient reports new breathlessness when walking. More visible effort is observed during conversation. No oxygen measurement, trend, history or current orders are supplied.

Known findings

Reported change with exertion; visible effort noted.

Not provided

Respiratory rate trend, pulse oximetry, blood gas, baseline, related symptoms and authorized support.

Reasoning limitation

Gas exchange cannot be established or ruled out from breathlessness alone. Do not choose a target saturation for an unknown person.

Classroom goal

By the simulated handoff, record and communicate appropriate assessment findings and discrepancies through the local escalation pathway.

Activities and rationale

Obtain supervised assessment, compare with baseline, verify the existing care plan and communicate significant change; all address missing critical information.

Fictional follow-up

The handoff states that assessment and communication occurred. Physiological improvement cannot be evaluated because follow-up measures are absent.

Evaluation

Document “clinical effect not yet evaluable.” Never invent oxygen response or treatment.

Skin integrity: care-plan example

From cues to evaluation — fictional educational example

A fictional adult reports discomfort while sitting. During an observed teaching scenario, a new area of skin color change is noted. The case gives no size, depth, location details or comparison.

Known findings

Self-reported discomfort and an observed skin change.

Missing findings

Prior condition, exact description, pain, pressure or moisture exposure, function, and a complete skin review.

Reasoning limitation

A new finding is not by itself a valid pressure-injury stage or verified cause.

Classroom goal

At the next fictional observation, document location and objective characteristics under the approved assessment method, comparing them with baseline.

Activities and rationale

Seek appropriate site assessment, document facts, check preventive plan and communicate relevant changes; use individualized protocols rather than fixed universal schedules.

Fictional follow-up

A comparable description is recorded. The vignette has no evidence of tissue healing.

Evaluation

Assessment/documentation goal addressed; healing or diagnosis is not established.

Mobility: care-plan example

From cues to evaluation — fictional educational example

A fictional person states “I could dress independently before; now I need help.” During a classroom exercise the person asks for assistance before standing. Safe mobility level is unspecified.

Known findings

Change reported in activity of daily living and request for help.

Missing findings

Actual baseline, functional capacity, restrictions, home environment, therapy plan and safety assessment.

Reasoned concern

Functional ability may have changed. Age, a walker or a medical diagnosis alone cannot replace assessment.

Classroom goal

At the next agreed fictional review, record whether one named dressing task is completed at the authorized assistance level.

Activities and rationale

Clarify meaningful goals, check the existing interdisciplinary plan and document task performance under supervision.

Fictional follow-up

The person completes one dressing step with a verbal cue.

Evaluation

The single task has been observed under the stated conditions; do not claim total independent mobility.

Compare four clinical questions

Why similar search terms do not imply interchangeable diagnoses

Pain

Ask how pain affects the person’s tasks; do not rely on a score alone. Repeat the same type of assessment after agreed care.

Breathing

Collect relevant respiratory and oxygenation findings; symptom labels do not prove impaired gas exchange. Respect escalation procedures.

Skin

Describe present findings and risks separately; do not stage or treat an unexplained lesion from a generic worksheet.

Mobility

Document baseline and current function in defined activities; do not treat assistive-device use as a diagnosis.

What should be common across these plans?

Precise initial cues, explicitly stated uncertainty, an observable outcome, the reason for each planned nursing activity, a later comparable observation where provided, and a clear statement of what remains unknown.

NCLEX-style reasoning practice

Original six-step fictional learning exercise; not an official NCLEX item

A fictional patient preparing to go home says: “I do not know what to do if my symptoms change.” A written discharge plan exists, but the vignette does not tell you the person’s preferred language, prior understanding or specific instructions.

1. Recognize cues

What is directly reported? What is missing?

2. Analyze cues

What are possible barriers to understanding, without making assumptions?

3. Prioritize hypotheses

What needs clarification before relying on the plan?

4. Generate solutions

What assessment or verified education could help?

5. Take action

What would the team document in a simulated approved teaching session?

6. Evaluate outcomes

How could a teach-back observation show what was understood?

Student task: Write one sentence for each step. The next page shows the explained answer; compare the reasoning, not exact wording.

Answer key: clinical judgment

Why each response is defensible

Recognize

Quote the person’s uncertainty. Do not invent symptoms or a literacy or language barrier.

Analyze

Understanding is unclear; the case does not show its cause. Ask what the person already understands and how information is best communicated.

Prioritize

Clarify the current approved instructions and the person’s ability to explain them before concluding that discharge teaching was successful.

Generate

Propose appropriate supervised teach-back of the actual discharge plan, with appropriate accessibility support if needed.

Take action

In the fictional classroom scenario, a supervised teaching session uses the existing plan and documents what the person can explain.

Evaluate

The person explains two points but misses the follow-up contact instruction. Document partial achievement and a need for clarification, not “teaching successful.”

Checklist before turning in a care plan

A quick quality rubric for nursing-school assignments

- I separated direct patient reports from observed findings.
- I listed at least one missing assessment detail that could change the interpretation.
- I did not replace a nursing concern with a medical diagnosis or unsupported code.
- My proposed goal names a concrete observation, method and review point.
- Each nursing activity has a reason related to the assessment or goal.
- I distinguish planned actions from actions actually completed.
- My evaluation uses provided later data — or explicitly says data are missing.
- I used an authorized classification reference for any formal label.
- I used the source or reference required by my course, without copying copyrighted taxonomies.

Grading yourself: Excellent work supports every item using case evidence. A polished-looking table with invented values or unsupported diagnostic codes is not a defensible answer.

Blank care-plan worksheet

Photocopy or print for a fictional teaching case

Case context and patient goal

Subjective data (quoted report)

Objective data and baseline

Missing assessment or safety information

Provisional concern + reasoning

Measurable expected outcome

Proposed activities and rationales

Follow-up observations / evaluation

Blank clinical judgment worksheet

Practice the six operations without a memorized label

Recognize cues: direct facts

Analyze cues: meanings and uncertainties

Prioritize hypotheses: why this order?

Generate solutions: justified options

Take action: authorized step in the fictional scenario

Evaluate outcomes: what is actually observed?

Blank outcome & evaluation worksheet

Turn an outcome statement into a usable comparison

Person-centered priority or concern

Baseline observation and conditions

Outcome: observable change + time + method

Activity proposed and rationale

Observation at fictional follow-up

Result: met, partially met, not met or not evaluable — why?

Terms and concepts

Plain-language study glossary

Assessment cue

A reported or observed fact that may matter to the person’s condition or goals.

Nursing diagnosis

A professional judgment about a human response or vulnerability, not automatically equivalent to a medical condition.

Outcome

An expected measurable response of the person, distinct from an action that a clinician performs.

Intervention

A care activity selected in the context of an individualized plan, roles, evidence and authorized policy.

Rationale

The reason the proposed activity is relevant to the documented assessment or outcome.

Evaluation

Comparing actual later observations with an expected outcome; a plan may need to be revised.

ADPIE

Assessment, Diagnosis, Planning, Implementation, Evaluation — a common educational nursing process mnemonic.

Clinical judgment model

A sequence of reasoning operations assessed in the NCLEX framework, not an official NANDA diagnosis list.

Sources and limitations

Primary professional references and further reading

American Nurses Association: The Nursing Process

https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process

NCSBN: 2026 NCLEX-RN Test Plan

https://www.ncsbn.org/publications/2026-nclex-rn-test-plan

NCLEX Test Plans (official)

https://www.nclex.com/test-plans

OpenStax: Pain Assessment

https://openstax.org/books/fundamentals-nursing/pages/30-4-pain-assessment

Open RN: Nursing Fundamentals

https://www.ncbi.nlm.nih.gov/books/NBK591807/

INKA / NANDA: Use and Licensing

https://nanda.org/use-and-licensing/

The references explain general nursing process, assessment and exam frameworks. The cases, solutions and templates in this workbook are original fictional educational constructions and have not been independently validated by a licensed clinical reviewer. They are not an official exam preparation product or substitute for clinical judgment.