NURSING CARE PLAN FOR BLADDER CANCER:

Assessment	Nursing Diagnosis	Goals/Outcomes	Nursing Interventions	Rationale	Evaluation	Documentation
Monitor urine color, volume, and clarity; assess for hematuria and dysuria.	Risk for altered urinary elimination due to urinary obstruction.	Patient maintains clear, adequate urine output with minimal discomfort.	Observe and record urine output hourly; perform catheter care as needed.	Early detection of changes prevents complications.	Urine output remains within normal limits; no new obstructions observed.	Record all urine assessments and interventions.
Assess for signs of infection such as fever, chills, or cloudy urine.	Risk for infection due to invasive procedures and catheterization.	Patient remains free from infection.	Administer prescribed antibiotics; maintain sterile technique during catheter care.	Reducing contamination lowers infection risk.	Patient's temperature remains stable; lab results show no infection.	Document vital signs, lab results, and antibiotic administration.
Evaluate the stoma site or catheter insertion	Risk for skin breakdown related to moisture and	Skin remains intact and free from irritation.	Clean skin gently with mild soap; apply protective	Protecting the skin minimizes breakdown and infection.	Skin appears healthy without signs	Record skin assessments and any care provided.

area for skin integrity.	chemical exposure.		barrier cream as ordered.		of redness or irritation.	
Check pain levels using a standardized pain scale.	Acute pain related to tumor growth or procedures.	Patient reports pain relief within acceptable limits.	Administer pain medication as prescribed; provide comfort measures.	Effective pain management improves recovery and comfort.	Patient's pain score is reduced to a tolerable level.	Document pain scores, medications given, and patient feedback.
Monitor abdominal status including bowel sounds and discomfort.	Risk for gastrointestinal complications from treatment interventions.	Maintain normal bowel function and reduce discomfort.	Encourage ambulation; monitor abdominal sounds; administer gastrointestinal medications if ordered.	Early detection of GI issues allows prompt intervention.	Normal bowel sounds are restored and discomfort is reduced.	Record findings from abdominal assessments and any interventions.
Assess emotional well-being and anxiety levels.	Anxiety related to diagnosis and treatment process.	Patient verbalizes reduced anxiety and demonstrates effective coping.	Provide clear education on the care plan; involve family members; refer to counseling	Emotional support enhances overall	Patient expresses understanding and shows less	Document educational interventions and patient's

			services as needed.	recovery and compliance.	anxiety during care.	emotional status.
Review overall fluid balance and laboratory data.	Risk for fluid imbalance due to treatment and urinary loss.	Maintain stable fluid and electrolyte balance.	Monitor input/output closely; assess lab results; adjust IV fluids as necessary.	Monitoring ensures early detection of imbalances.	Lab results and fluid balance remain within target ranges.	Record fluid intake/output and laboratory values consistently.