Sample Nursing Care Plan - Chapter 4

Recognize Cues

Subjective Data: “Severe” abdominal pain, states, “I’m so uptight I will never be able to sleep tonight”, states, “my mouth is so dry”

Objective Data: Constant pacing, repetitive questions, avoiding eye contact during interactions, fidgeting with call light, eyes darting around room, appears tense with strained facial expression, VS T 98, P 104, R 30, BP 180/96, skin feels sweaty (diaphoretic) and cool to the touch

Analyze/Cluster Cues	**Prioritize Cluster:**
Relevant data cluster 1: “severe” abdominal pain unable to be managed in Emergency Department, appears tense with strained facial expression, VS T 98, P 104, R 30, BP 180/96, skin feels sweaty (diaphoretic)	**What is your immediate priority:** “severe” abdominal pain unable to be managed in Emergency Department, appears tense with strained facial expression, VS T 98, P 104, R 30, BP 180/96, skin feels sweaty (diaphoretic)
Relevant data cluster 2: states, “I’m so uptight I will never be able to sleep tonight”, states, “my mouth is so dry”, constant pacing, repetitive questions, avoiding eye contact during interactions, fidgeting with call light, eyes darting around room, appears tense with strained facial expression, VS P 104, R 30, BP 180/96, skin feels sweaty (diaphoretic) and cool to the touch	**Why is this a priority?** Mark is clearly showing signs of anxiety, likely having to do with his pain and needing to undergo testing in the morning. While this is important to address, his severe abdominal pain is more pressing as severe pain can contribute to worsening anxiety. His blood pressure is also dangerously high, which likely is due to unmanaged severe abdominal pain. Effectively managing Mark’s pain most likely will help calm his anxiety in the process.
Relevant data cluster 3: states, “I’m so uptight I will never be able to sleep tonight”	

Nursing Hypothesis (Nursing Diagnosis)	**Related To**
Acute pain	Physical injury agent
As Manifested By "Severe" abdominal pain, appearing tense with strained facial expression, diaphoretic skin, VS P 104, R 30, BP 180/90	
Generate Solutions (Outcome Goal) Client will have a reduction in pain	**Generate Solutions (SMART Outcome Criteria)** Client will rate pain at a level of 3/10 or less and show a decrease in diaphoresis and return of VS to baseline within one hour of oral pain medication administration or within 30 minutes of parenteral pain medication administration.
Plan (Nursing Interventions) **"The nurse will …"** **1.** Assess the client's self-report of pain using an appropriate pain scale routinely and as needed. **2.** Administer analgesic and dose based on orders reflecting client report of pain severity and response to previous dose. **3.** Assist the client to identify resources for coping with psychological impacts of pain.	**Rationale** **1.** Self-reporting pain is considered the most reliable indicator of pain presence, level, and associated characteristics.[1] **2.** Safe and effective pain management requires dose adjustments based on pain levels and evaluation of response to treatment.[1] **3.** Utilizing cognitive-behavioral strategies help enhance the client's sense of self-control and actively participating in their own care.[1]
Take Action (Implement Interventions)	
Evaluating outcomes. Met **X** Partially Met ■ Not Met *Client rates pain at 4/10 after pain medications administered. VS P 98, BP 160/80, R 26, no diaphoresis noted.*	**Revision:** 2 new interventions: **1.** Administer supplemental analgesic dosing as ordered to keep pain at a 3/10 or less. **2.** Teach and implement nonpharmacological pain management interventions as appropriate.

Reference: Ackley, B, Ladwig, G, Makic, M. (2017). Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care, 11th ed.