

Nursing Care Plan for a Patient with Nausea, Anxiety, and Abdominal Pain

Assessment	Diagnosis	Planning (Goals/Expected Outcomes)	Implementation	Rationale	Evaluation
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<ul style="list-style-type: none"> - Patient appears diaphoretic and is clutching her abdomen, indicating nausea and abdominal pain. - Anxious appearance and elevated heart rate (108 bpm), possibly due to discomfort or stress. - Reports abdominal pain; hypoactive bowel sounds and mild tenderness upon palpation. 	<p>Acute Pain related to abdominal discomfort, as evidenced by clutching abdomen, diaphoresis, and verbal reports of pain.</p>	<ul style="list-style-type: none"> - The patient will report a reduction in abdominal pain, rated below 3/10 on a pain scale within 2 hours. - The patient will demonstrate relaxed posture and reduced vital signs indicating lower pain and anxiety levels. 	<ol style="list-style-type: none"> 1. Assess pain intensity, location, and quality regularly using a standardized pain scale (0-10). 2. Provide a comfortable position, such as semi-Fowler's, to relieve abdominal discomfort. 3. Administer prescribed analgesics as ordered, evaluating response within 30 minutes. 4. Encourage slow, deep breathing exercises to help manage discomfort and reduce anxiety. 	<ol style="list-style-type: none"> 1. Pain assessment aids in monitoring pain levels and guiding effective interventions. 2. Semi-Fowler's position can relieve pressure on the abdomen and reduce discomfort. 3. Analgesics reduce pain, allowing the patient to feel more comfortable. 4. Relaxation techniques can decrease anxiety and the perception of pain. 	<ul style="list-style-type: none"> - Patient reports abdominal pain is reduced to 3/10 or less. - Patient's posture and facial expressions indicate comfort, and vital signs show improvement.
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<p>- Patient appears anxious, frequently looking around, and has a slightly elevated respiratory rate (22 breaths/min).</p> <p>- The patient inquires about the potential causes of her symptoms, suggesting uncertainty and worry.</p>	<p>Excessive anxiety related to situational stress, as evidenced by anxious appearance, questioning, and elevated respiratory rate.</p>	<p>- The patient will verbalize understanding of her symptoms and demonstrate reduced anxiety within 2 hours.</p> <p>- The patient will demonstrate techniques, such as deep breathing, to reduce anxiety.</p>	<ol style="list-style-type: none"> 1. Provide clear, concise explanations about the current assessment and care to reduce uncertainty. 2. Encourage the patient to ask questions and express concerns, offering emotional support. 3. Teach relaxation techniques, including deep breathing and guided imagery, to reduce anxiety. 4. Limit environmental stimuli and provide a calm, quiet room to reduce sensory overload. 	<ol style="list-style-type: none"> 1. Understanding the care plan reduces anxiety by addressing the unknown. 2. Emotional support fosters trust and helps the patient feel more at ease. 3. Relaxation techniques lower stress levels and promote a sense of control. 4. Reducing stimuli can prevent further anxiety from sensory overload. 	<p>- Patient reports feeling more relaxed and expresses understanding of her symptoms and care.</p> <p>- Patient uses relaxation techniques to manage anxiety effectively.</p>
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<ul style="list-style-type: none"> - Patient is diaphoretic, clutching her abdomen, and reports feeling nauseous. - Mild tenderness on abdominal palpation and hypoactive bowel sounds. 	<p>Ineffective nausea self-management related to gastrointestinal discomfort, as evidenced by diaphoresis, clutching abdomen, and patient's report of nausea.</p>	<ul style="list-style-type: none"> - The patient will report decreased nausea within 1 hour. - The patient will be able to tolerate oral intake without nausea or vomiting. 	<ol style="list-style-type: none"> 1. Assess nausea severity using a nausea scale and inquire about potential triggers. 2. Administer prescribed antiemetics as ordered, and evaluate the effectiveness within 30 minutes. 3. Encourage sips of clear fluids to prevent dehydration, as tolerated. 4. Offer small amounts of dry foods (e.g., crackers) if tolerated, once nausea subsides. 	<ol style="list-style-type: none"> 1. A scale provides a baseline for assessing nausea severity and treatment response. 2. Antiemetics can alleviate nausea, improving the patient's comfort. 3. Sips of fluid help prevent dehydration, especially when oral intake is limited. 4. Dry foods are less likely to exacerbate nausea and can improve energy levels. 	<ul style="list-style-type: none"> - Patient reports a decrease in nausea and tolerates sips of clear fluids without discomfort. - No signs of dehydration; the patient's vital signs remain stable.
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<p>- Vital signs: Elevated heart rate (108 bpm) and respiratory rate (22 breaths/min). - Reports abdominal pain and appears anxious, possibly increasing physiological stress.</p>	<p>Risk for Inadequate fluid volume related to nausea and decreased oral intake.</p>	<p>- The patient will maintain adequate hydration status, as evidenced by stable vital signs and adequate urine output. - The patient will be able to tolerate fluids orally without nausea.</p>	<ol style="list-style-type: none"> 1. Monitor intake and output to assess fluid balance and early signs of dehydration. 2. Encourage the patient to take sips of water every 30 minutes if tolerated. 3. Monitor vital signs every 2 hours to detect any signs of dehydration or hemodynamic changes. 4. Administer IV fluids as ordered if oral intake remains insufficient. 	<ol style="list-style-type: none"> 1. Monitoring provides early detection of fluid imbalances to prevent complications. 2. Frequent, small sips can improve tolerance to fluids and support hydration. 3. Changes in vital signs may indicate fluid imbalance, requiring prompt intervention. 4. IV fluids prevent dehydration when oral intake is insufficient to meet fluid needs. 	<p>- Patient maintains adequate urine output and shows no signs of dehydration. - Vital signs remain stable, and the patient tolerates oral fluids.</p>
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<p>- Diaphoresis, anxious appearance, and frequent clutching of the abdomen.</p> <p>- Temperature of 37.7°C, mild tachycardia, and elevated respiratory rate.</p>	<p>Hyperthermia related to stress and pain-induced metabolic increase, as evidenced by elevated temperature and heart rate.</p>	<p>- The patient will maintain a normal body temperature within 4 hours.</p> <p>- The patient's heart rate and respiratory rate will return to baseline.</p>	<ol style="list-style-type: none"> 1. Monitor the patient's temperature, heart rate, and respiratory rate every 2 hours to track any changes. 2. Encourage the patient to rest and use a cool compress on her forehead to reduce body temperature. 3. Administer antipyretics as ordered if the temperature exceeds 38°C. 4. Offer fluids to support hydration and help reduce fever. 	<ol style="list-style-type: none"> 1. Frequent monitoring helps track temperature trends and assess intervention effectiveness. 2. Rest and cooling measures help bring down body temperature without medication. 3. Antipyretics reduce fever, especially if non-pharmacological measures are insufficient. 4. Hydration supports thermoregulation and helps lower body temperature naturally. 	<p>- Patient's temperature is maintained below 38°C.</p> <p>- Heart rate and respiratory rate return to baseline levels.</p>
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