

NURSING CARE PLAN

DATE & INITIAL	NURSING DIAGNOSIS	PATIENT OUTCOMES	RELATED INTERVENTIONS	EVALUATION
9/16/20 CC	Acute Pain r/t C section AEB:	<ul style="list-style-type: none"> Pt will verbalize a decrease in pain of 2/10 	<ul style="list-style-type: none"> Assess pain q4hr and prn. (0600,1000,1400,1800,2200) <i>assessment of pain will help better</i> 	<ul style="list-style-type: none"> Pt denies pain during assessment.

	<ul style="list-style-type: none"> • Verbalizes pain 6/10 • c/o pain during fundal assessment • c/o nausea and vomiting • facial grimacing • Increased BP of 132/76, HR 90 	<ul style="list-style-type: none"> • Pt will report a decrease in pain during fundal assessment • Pt will be free of nausea and vomiting • Pt will show no facial grimacing during assessment • Pt will have a decrease in BP of systolic 110-120 and diastolic of 60-80. HR will be between 60-80 	<p><i>control pts pain.</i></p> <ul style="list-style-type: none"> • Fundal assessment bid and prn. (0600, 1800) <i>assessment of fundus and charting of placement will help the nurse determine if pain is due to boggy fundus.</i> • Assess for nausea and vomiting q4hrs and prn. (0600,1000,1400,1800,2200) <i>bring attention to signs and symptoms associated with pain will help the nurse in evaluating and controlling pain.</i> • Assess for facial grimacing q4hrs and prn. (0600,1000,1400,1800,2200) <i>when pt doesn't verbalize pain nurse will be able to better evaluate if the pt is experiencing pain.</i> • BP and HR q4hrs and prn. (0600,1000,1400,1800,2200) <i>monitoring of vital signs will help determine if the pain is under control.</i> 	<ul style="list-style-type: none"> • Fundus is 3cm below umbilicus and firm with small amount of lochia. • Pt denies any nausea and vomiting. • Pt shows no signs of facial grimacing. • BP 109/68 and HR 79 <p>Goals met. May d/c POC. Cindy Cisco, FRMCSO 09/16/20</p>
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