Patients info label here

Acute pain

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Acute pain *Related factors:* Imbalance between milk supply and infant demand Accumulation of fluid in abdominal and peritoneal cavity Actual infusion of dialyse Arterial inflammation Bladder distention Bladder spasm Bowel obstruction catheter irritation Chemical irritation of the parietal peritoneum (toxins) Chest tube Coronary spasm Deformities Destruction of skin Excoriated perineal inflammation Fracture incision Inflamed lung Inflamed skin Inflammatory process of bone tissues Injury agents (biological, chemical, physical, psychological Insertion of catheter Local peritonitis Manipulation of injured tissues Mastitis Meningeal irritation Myocardial ischemia Necrosis Obstruction or ductal spasm Persistent coughing Pneumothorax Presence of nasogastric or orogastric feeding tube Pressure on brain tissues Psychological impact of loss of body part Result from tissue and nerve trauma *Symptoms / Risk factors:* Angina Antalgic positioning to avoid pain Changes in appetite and eating Chest pain Crampy pain Discomfort in surgical areas Expressive behavior (e.g., restlessness, moaning, crying) Facial mask Irritability Tachycardia - High blodpressure - abnormal vital signs Verbal or coded report *Outcome / Goal:* Patient appears relaxed and comfortable Patient verbalizes relief of pain Patient verbalizes relief of pain and spasm Report pain is relieved or controlled Verbalize understanding of phantom pain		**Pain Management** Administer O2 as orderd Asses cardiac status during pain occurrence: vital signs, skin changes and ECG Asses cause of pain: location, character and duration Assess concurrence of spasm or pain with irrigation or catheter care Assess reports of abdominal cramping or pain Consider patient-controlled analgesia (PCA) for pain control. Consider providing Vasodilators, such as nitrates (if angina) Elevate affected part using for instance pillow's Elevate the head of bed 30 to 45 degr. unless contraindicated Encourage ambulation and independence as tolerated Establish pain management plan with client, family, and healthcare providers Evaluate pain level frequently. Explain that treatment of infection will also decrease pain Instruct patient to relax and rest while occurrence of pain Investigate verbal reports of pain Keep arm elevated on pillows while the patient in bed Maintain comfortable environmental temperature Maintain nothing by mouth (NPO) status if indicated Maintain traction on the catheter Make sure the dialyse fluids are warm Note factors that aggravate and relieve pain Obs vital signs_____ Optimize the patient's comfort in bed Plan for aggressive pain management, as indicated Review factors that aggravate or alleviate pain. Support head and neck with pillows. Teach proper technique in giving eye medications. **Circulatory Precautions** Administer blod, plasma as indicated Avoid injury to affected area Avoid leg crossing Change positions at least every hour Check wound dressing and output from drain Chek wound dressing (bleeding) Keep extremity in depended position Keep extremity warm Maintain adequate hydration to prevent increased blood viscosity Monitor affected extremities for pulse,skin color, temprature and sensations Reduce external pressure points Refrain from taking blood pressure in affected extremity **Distraction** Decide which type of distraction therapy can be used: music, book, TV, puzzle Provide diversional activities, such as reading and watching Television Provide quiet diversional activities, such as listening to a radio or audio book **Analgesic Administration** Administer medication (NTG,Morphin,Aspirin) as prescribet Administer medication as prescribet Obs. pain (effectivnes of medication) **Patient-Controlled Analgesia (PCA) Assistance** Assist patient to administer an appropriate bolus loading dose of analgesic Document patient's pain, amount and frequency of drug dosing, and response Teach patient how to use the PCA device Validate that the patient can use a PCA device	

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