Acute Pain Nursing Care Plan

A five-column acute pain plan built on multimodal analgesia, pre-emptive dosing before activity, sedation monitoring, and functional-goal outcomes rather than a pain score of zero.

QUICK ANSWER

For acute pain, prioritize: Acute pain → ineffective breathing pattern → impaired mobility → risk for constipation → anxiety. Core interventions are validated assessment every 4 h with reassessment 30–60 min after each dose, multimodal analgesia (scheduled acetaminophen + NSAID + PRN opioid), dosing 30 minutes before activity, POSS sedation monitoring before every opioid dose, and a bowel regimen started with the first opioid. Set outcomes to the patient's functional goal, not zero pain.

Assessment (subjective + objective)

Subjective (OLDCARTS): Onset 2 h post-op; Location right lower quadrant; Duration constant; Character sharp with movement; Aggravated by ambulation and coughing; Relieved partially by splinting; Timing worse on inspiration; Severity 8/10 at rest, 9/10 with movement. Patient's functional goal: "I want to be able to walk to the bathroom."

Objective: HR 108, BP 152/90, RR 24 shallow, guarding, grimacing, refuses to cough and deep-breathe, diaphoretic, incisional site clean and dry, FLACC 6 in a nonverbal patient.

Priority NANDA-I diagnoses

1. **Acute pain** related to surgical tissue trauma AEB self-report of 8/10, HR 108, guarding, and refusal to perform incentive spirometry.
2. Ineffective breathing pattern AEB shallow RR 24 and splinting (pain-limited ventilation).
3. Impaired physical mobility related to pain AEB refusal to ambulate.
4. Risk for constipation (opioid therapy).
5. Anxiety related to fear of uncontrolled pain.

NOC outcomes (SMART)

- Pain ≤ 3/10 (or patient's stated functional goal) within 60 minutes of intervention.
- Patient performs incentive spirometry ≥ 10 times/hour while awake within 12 h.
- Patient ambulates 50 feet with one assist within 24 h.
- HR < 100 and RR 12–20 within 4 h.
- Bowel movement within 48 h of opioid initiation.

NIC interventions and rationale

- **Assess pain with a validated tool every 4 h and 30–60 min after every intervention** — reassessment is the single most-missed documentation element and is what proves the intervention worked.
- **Use multimodal analgesia: scheduled acetaminophen + NSAID (if not contraindicated) + opioid PRN for breakthrough** — multimodal regimens lower total opioid dose, nausea, sedation, and length of stay.
- **Medicate 30 minutes before ambulation, dressing changes, and physical therapy** — pre-emptive dosing prevents the pain spiral that makes patients refuse mobility.

- **Non-pharmacological adjuncts: repositioning, splinting a pillow for cough, cold/heat per order, distraction, guided imagery** — additive analgesia with no respiratory risk.
- **Monitor sedation with POSS or RASS and RR before each opioid dose** — sedation precedes respiratory depression; a sedation scale detects it earlier than RR alone.
- **Start a scheduled bowel regimen (stimulant laxative ± softener) with the first opioid dose** — opioid-induced constipation is preventable, not treatable-after-the-fact.
- **Accept the patient's self-report as the standard** — clinician estimation systematically under-treats pain, especially in Black patients and in patients with substance use history.
- **Teach the functional goal model of pain control** — "pain that lets you cough, walk, and sleep" is a more achievable target than zero.

Evaluation

Sixty minutes after multimodal dosing: pain 3/10, HR 88, RR 16 with deep excursion, patient completes 10 incentive-spirometry breaths and ambulates 60 feet with one assist. Bowel movement documented at hour 36. All five outcomes met.

Frequently Asked Questions

What is the difference between acute pain and chronic pain in NANDA-I?

Acute pain has an expected or predictable end (less than 3 months) and is usually tied to identifiable tissue injury. Chronic pain persists beyond 3 months, often without ongoing tissue damage, and the outcomes shift from pain elimination to function and quality of life.

How do I assess pain in a nonverbal patient?

Why does the care plan schedule acetaminophen instead of giving it PRN?

Scheduled non-opioid baseline analgesia keeps serum levels steady, so opioids only cover breakthrough pain. PRN-only dosing produces peaks and troughs and drives up total opioid consumption.

What should I chart to defend an opioid dose?

Sources & Further Reading

1. **Chou, R., et al..** Management of Postoperative Pain: A Clinical Practice Guideline. Journal of Pain, 17(2), 131–157.
2. **Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.).** NANDA International Nursing Diagnoses: Definitions and Classification, 2024–2026. Thieme.

Related Resources

→ Full nursing care plan library→ Post-operative care plan→ Anxiety care plan→ NANDA-I diagnosis list