Pain Nursing Care Plan

All plans per Osmosis clinical education standards.
Prepare for print/PDF export in browser for documentation.

Comprehensive Nursing Care Plan for Pain

Prepared by: Professor, 20 Years Nursing Education

Fifteen (15) evidence-based nursing diagnoses for pain—each with assessment, diagnosis, goal, planning, minimum seven interventions, and evaluation—organized in the Osmosis style for clinical clarity.

Color coded | Osmosis concise style | Optimized for continuous PDF export

1. Acute Pain

Nursing Assessment
- Self-reported pain scale 0–10
- Description: location, quality, duration, intensity, triggers
- Observe nonverbal cues (grimacing, guarding)
- Associated symptoms: nausea, anxiety, VS changes
- Impact on mobility, sleep, and daily function
- Response to prior pain relief methods

Diagnosis Statement
Acute pain related to physical injury/trauma/inflammatory process as evidenced by patient report, verbal and nonverbal cues, and disruption of daily activities.

Goal
- Reduce pain to ≤3/10 within 30 minutes of intervention
- Increase comfort level and improve ability to perform ADLs

Planning
- Implement multimodal interventions: pharmacologic and non-pharmacologic
- Monitor pain levels and side effects regularly
- Educate patient/family on pain management strategies

Evaluation
- Pain score ≤3/10 within 30 minutes of intervention
- Improved comfort and ability to participate in care/ADLs
- No adverse effects from interventions

Interventions (≥7)
1. Assess pain characteristics (intensity, type, onset, location, duration) every 2 hours or as needed.
2. Administer prescribed analgesics (NSAIDs, opioids as appropriate); monitor for side effects.
3. Apply non-pharmacologic techniques: distraction, guided imagery, music therapy.
4. Use cold or heat packs as indicated to the painful area.
5. Reposition patient for optimal comfort; use supports and pillows.
6. Encourage relaxation and controlled breathing exercises.
7. Educate patient and family about pain management plan and importance of reporting pain.
8. Monitor for adverse drug reactions and escalate care if pain is uncontrolled.

2. Chronic Pain

Nursing Assessment
- Assess pain characteristics: persistent duration (>3 months), patterns, impact on quality of life
- Evaluate emotional/psychological status (depression, hopelessness, irritability)
- Review coping mechanisms and pain relief efficacy over time
- Observe for changes in appetite, mobility, dependence on others
- Identify support systems and barriers

Diagnosis Statement
Chronic pain related to underlying disease (e.g. arthritis, neuropathy) as evidenced by persistent pain, functional limitations, and emotional distress.

Goal
- Patient verbalizes acceptable pain level (≤4/10) in daily activities
- Improves coping and psychological well-being

Planning
- Implement individualized, multimodal pain strategies
- Encourage long-term coping mechanisms
- Involve interdisciplinary team as needed

Evaluation
- Patient reports stable, tolerable pain levels
- Increased participation in social/physical activities
- Demonstrates use of positive coping strategies

Interventions (≥7)
1. Assess pain and functional impact at least daily using standardized tools.
2. Establish a collaborative pain management plan (with MD, PT, OT).
3. Administer prescribed analgesics and evaluate dosing schedule adherence.
4. Encourage cognitive-behavioral interventions and support groups.
5. Recommend adaptive devices for independence in ADLs.
6. Promote pacing of activities to conserve energy and minimize flare-ups.
7. Offer referrals for psychosocial counseling and peer support as needed.
8. Monitor for side effects and signs of medication misuse/overuse.

3. Impaired Physical Mobility

Nursing Assessment
- Assess ROM, strength, balance, gait, and pain on movement
- Document limitations in ADLs/mobility and assistive device needs
- Review injury history, duration of immobility
- Evaluate for contractures, muscle atrophy, skin integrity
- Observe for signs of fatigue or misuse of limbs

Diagnosis Statement
Impaired mobility related to pain/discomfort as evidenced by limited movement, dependence on assistance, and reluctance to move.

Goal
- Increase mobility and functional independence
- Prevent complications of immobility

Planning
- Coordinate pain management with activity schedule
- Implement range-of-motion and exercise regimen as tolerated

Evaluation
- Demonstrates improved movement/strength
- Requires less assistive support
- No new complications (e.g. pressure injuries, DVT)

Interventions (≥7)
1. Assess baseline mobility and monitor progress regularly.
2. Schedule pain medication prior to mobility sessions for optimal comfort.
3. Assist with repositioning, transfers, ambulation using proper body mechanics.
4. Implement active/passive ROM exercises per PT recommendations.
5. Encourage participation in self-care and ADLs, using adaptive aids if needed.
6. Educate family and patient on safe mobility techniques to prevent injury.
7. Monitor for signs of complications (e.g. falls, skin breakdown, muscle atrophy).
8. Refer to physical or occupational therapy as indicated.

4. Disturbed Sleep Pattern

Nursing Assessment
- Assess duration and quality of sleep; usual sleep routine
- Inquire about nocturnal pain, awakenings, fatigue
- Assess use of sleep aids, non-prescription remedies
- Identify environmental factors affecting sleep (noise, light)

Diagnosis Statement
Disturbed sleep pattern related to pain and discomfort as evidenced by patient-reported insomnia, frequent awakenings, and daytime fatigue.

Goal
- Restore adequate sleep duration and quality
- Decrease nocturnal pain and promote restfulness

Planning
- Address pain during sleep hours with scheduled interventions
- Minimize external/environmental sleep disruptors

Evaluation
- Patient reports improved sleep quality
- Observes decreased fatigue during day
- Less nocturnal awakenings due to pain

Interventions (≥7)
1. Assess sleep patterns and fatigue levels each shift.
2. Time pain medication to coincide with patient's preferred sleep schedule.
3. Promote sleep hygiene (dark, quiet, cool room; avoid electronics before bedtime).
4. Encourage relaxation or mindfulness practices at bedtime.
5. Teach patient non-pharmacologic pain relief methods for nighttime use.
6. Minimize unnecessary interruptions during nighttime hours.
7. Collaborate with provider for possible sleep aids/adjust medications if appropriate.
8. Evaluate effectiveness of interventions by tracking sleep logs.

5. Activity Intolerance

Nursing Assessment
- Assess tolerance for ADLs, exertion, and impact of pain
- Monitor vital signs, fatigue, and recovery response to activity
- Identify contributing comorbidities or medications
- Evaluate emotional/psychological barriers to activity

Diagnosis Statement
Activity intolerance related to acute/chronic pain as evidenced by reported/exertional fatigue, abnormal VS response to activity, and decreased participation in ADLs.

Goal
- Increase endurance and participation in ADLs
- Maintain hemodynamic stability with activity

Planning
- Individualize activity schedule based on tolerance
- Gradually increase level/duration of activity

Evaluation
- Patient completes planned activities with reduced pain/fatigue
- Vital signs remain stable with movement

Interventions (≥7)
1. Assess current activity tolerance and response to exertion.
2. Coordinate pain interventions prior to planned activity periods.
3. Provide assistance with ADLs while promoting independence when possible.
4. Break tasks into smaller, manageable steps and allow for frequent rest.
5. Teach energy-conservation strategies to avoid overexertion.
6. Encourage use of mobility aids/devices as needed.
7. Gradually increase level of activity based on improvement and tolerance.
8. Monitor for adverse symptoms (dizziness, SOB, abnormal VS) during activity.

6. Anxiety

Nursing Assessment
- Assess emotional response and level of anxiety (scales or observations)
- Identify patient's knowledge and perceptions of pain/cause
- Observe for restlessness, irritability, physiological symptoms (tachycardia, sweating)
- Explore coping strategies, support systems
- Assess for underlying mental health conditions

Diagnosis Statement
Anxiety related to anticipation of pain and limited understanding as evidenced by verbalization, hypervigilance, and physiologic arousal.

Goal
- Patient expresses reduced anxiety and improved sense of control
- Demonstrates use of coping techniques

Planning
- Provide timely pain relief and information
- Encourage open communication of fears and expectations

Evaluation
- Patient verbalizes reduction of anxiety
- Uses relaxation or coping skills independently

Interventions (≥7)
1. Assess anxiety level and triggers each shift; document changes.
2. Provide clear, concise information about procedures, expected pain, and pain control options.
3. Use therapeutic communication; listen to concerns and validate experiences.
4. Introduce relaxation methods: deep breathing, progressive muscle relaxation.
5. Encourage involvement in care and decision-making.
6. Utilize distraction (music, visualization, hobbies) during procedures or pain episodes.
7. Refer to mental health professionals for persistent or severe anxiety.
8. Support use of prescribed anxiolytics, if appropriate.

7. Interrupted Family Processes

Nursing Assessment
- Assess family dynamics, communication, and role changes due to pain
- Identify stressors, support systems, and caregiving capabilities
- Observe for family member fatigue, confusion, or distress

Diagnosis Statement
Interrupted family processes related to patient's pain and hospitalization as evidenced by role changes, stress, and altered communication patterns.

Goal
- Restore effective family communication and support
- Decrease stress and conflict related to care

Planning
- Encourage open dialogue and problem solving
- Facilitate involvement of relevant support services

Evaluation
- Family expresses better understanding and coping
- Improved support for patient and caregivers

Interventions (≥7)
1. Assess family's understanding and expectations regarding pain and recovery.
2. Encourage family presence, participation, and feedback in care routines.
3. Provide regular, factual updates on patient's condition and care plan.
4. Facilitate family meetings to address concerns and distribute caregiving roles.
5. Refer to counseling, social work, or spiritual care as needed.
6. Teach family about effective communication and stress management.
7. Identify and address individual family member needs/burdens.
8. Provide resources for community support groups and respite care.

8. Ineffective Coping

Nursing Assessment
- Assess patient's typical coping strategies and recent changes
- Evaluate emotional/behavioral responses to pain
- Screen for signs of withdrawal, depression, anger, substance use
- Identify available supports and prior successful coping methods

Diagnosis Statement
Ineffective coping related to persistent pain and stress as evidenced by ineffective adaptation, emotional lability, and expression of helplessness.

Goal
- Patient demonstrates positive coping skills and emotional adjustment

Planning
- Encourage adaptive coping mechanisms
- Link to interdisciplinary support as needed

Evaluation
- Demonstrates use of healthy coping methods
- Seeks support as needed

Interventions (≥7)
1. Assess coping mechanisms and effectiveness; provide feedback.
2. Encourage patient to express emotions in a supportive environment.
3. Help patient set realistic goals for pain management and rehabilitation.
4. Teach positive coping strategies (journaling, guided imagery, mindfulness).
5. Provide access to counseling and peer support programs.
6. Promote involvement in decision-making about care and pain control.
7. Collaborate with social work, psychology, or chaplaincy as indicated.
8. Monitor for maladaptive coping (substance use, isolation, anger) and intervene early.

9. Risk for Infection

Nursing Assessment
- Assess for risk factors: wounds, invasive devices, compromised immunity
- Monitor for signs/symptoms of infection: fever, redness, drainage, malaise
- Review recent procedures, surgeries, breaks in skin integrity
- Monitor laboratory markers (WBC, cultures if available)

Diagnosis Statement
Risk for infection related to pain-induced immobility, tissue breakdown, or compromised barriers as evidenced by presence of risk factors.

Goal
- Prevent development of new infections

Planning
- Implement infection prevention protocols
- Educate patient/family on infection risk

Evaluation
- No signs/symptoms of infection develop
- Patient/family verbalize understanding of prevention methods

Interventions (≥7)
1. Strictly follow hand hygiene and standard precautions at every encounter.
2. Inspect wounds and invasive device sites every shift for infection signs.
3. Change dressings using clean/sterile technique per protocol.
4. Encourage mobilization and repositioning to prevent pressure injuries/skin breakdown.
5. Educate patient/family on signs of infection and when to notify provider.
6. Ensure proper nutrition and hydration to support immune defense.
7. Monitor laboratory parameters and report abnormal findings promptly.
8. Escort or remind patient of importance of immunization as appropriate.

10. Deficient Knowledge

Nursing Assessment
- Assess patient/family baseline knowledge of pain management and cause
- Identify misconceptions, information needs, or learning barriers
- Determine learning style and readiness

Diagnosis Statement
Deficient knowledge related to pain management, disease process, or medication as evidenced by information gaps and incorrect assumptions.

Goal
- Patient/family will verbalize understanding of pain and management plan
- Demonstrate safe pain control techniques

Planning
- Provide tailored education and written instructions
- Reinforce learning with demonstration and teach-back

Evaluation
- Patient correctly answers questions about pain plan and medications
- Adheres to recommended interventions and precautions

Interventions (≥7)
1. Assess current knowledge about pain, management options, and medications.
2. Use simple language, visual aids, and repetition to explain concepts.
3. Demonstrate techniques (medication self-administration, TENS, ice/heat packs).
4. Provide written instructions with key points and emergency contact info.
5. Encourage self-monitoring of pain and use of pain diary.
6. Instruct on non-pharmacologic interventions (e.g. relaxation, distraction strategies).
7. Review potential side effects, safety issues, and when to call for help.
8. Engage family/caregivers in teaching sessions and verify understanding with teach-back.

11. Imbalanced Nutrition: Less than Body Requirements

Nursing Assessment
- Obtain anthropometric and weight trends
- Inquire about appetite, taste changes, meal intake
- Assess for pain's effect on eating and digestion
- Monitor for symptoms (nausea, constipation, dry mouth) impacting nutrition

Diagnosis Statement
Imbalanced nutrition: less than body requirements related to pain and decreased intake as evidenced by weight loss, poor appetite, and suboptimal lab markers.

Goal
- Achieve and maintain optimal nutritional status
- Stabilize weight and oral intake

Planning
- Schedule pain relief before meals
- Collaborate with nutrition and dietary team

Evaluation
- Maintains or gains weight; meets daily intake goals
- Symptoms affecting nutrition decrease

Interventions (≥7)
1. Assess intake, preferences, and barriers to eating daily.
2. Time pain medication to maximize comfort during meals.
3. Offer small, frequent, high-calorie/high-protein snacks.
4. Adapt food consistency based on swallowing and digestion ability.
5. Collaborate with dietitian for individualized nutrition plan.
6. Encourage family involvement at mealtimes to promote intake.
7. Address symptoms (nausea, dry mouth, dental issues) promptly.
8. Monitor lab values (albumin, prealbumin, electrolytes) and weight regularly.

12. Risk for Powerlessness

Nursing Assessment
- Assess perception of control over pain and care decisions
- Observe for helplessness, low motivation, nonparticipation
- Evaluate patient's use of resources/self-advocacy

Diagnosis Statement
Risk for powerlessness related to persistent pain and hospital dependency as evidenced by fear of loss of control, verbalization of helplessness, or withdrawal.

Goal
- Patient feels empowered to make decisions in pain management and self-care

Planning
- Facilitate shared decision-making and self-efficacy building

Evaluation
- Patient actively participates in care and expresses control over choices

Interventions (≥7)
1. Assess for expressions/behaviors of powerlessness.
2. Encourage patient input into daily care and pain management choices.
3. Offer choices when possible to foster autonomy (medication timing, activity time, coping skills).
4. Teach patient problem-solving and self-advocacy skills.
5. Acknowledge and validate patient feelings regarding illness experience.
6. Collaborate with social services if needed for ongoing support.
7. Ensure readily available resources for self-management.
8. Reinforce prior positive achievements or self-management experiences.

13. Self-Care Deficit

Nursing Assessment
- Assess patient's ability to perform bathing, dressing, toileting, feeding
- Note pain's effect on self-care performance
- Identify environmental/equipment barriers
- Determine desire for independence versus assistance

Diagnosis Statement
Self-care deficit related to pain and/or physical limitation as evidenced by inability to independently complete daily grooming, hygiene, or toileting.

Goal
- Patient maximizes independence in self-care
- Requires minimal assistance for daily tasks

Planning
- Use pain management strategies before activity
- Provide adaptive equipment and education

Evaluation
- Completes targeted self-care tasks independently or with reduced help

Interventions (≥7)
1. Assess baseline and changing self-care abilities daily.
2. Schedule pain relief prior to periods of self-care activity.
3. Encourage participation through gentle encouragement, not rushing patient.
4. Introduce or reinforce use of adaptive devices (grab bars, long-handled brushes).
5. Allow time for patient to complete tasks, offering minimal but needed assistance.
6. Educate patient/family on energy-saving and safe self-care techniques.
7. Monitor and prevent potential complications (falls, skin breakdown, infection).
8. Refer to occupational therapist for further evaluation and training.

14. Ineffective Breathing Pattern

Nursing Assessment
- Assess respiratory rate, pattern, and effort at rest/activity
- Observe for splinting, shallow respirations, use of accessory muscles
- Note any abnormal breath sounds, cough, or oxygen saturation changes
- Identify pain triggers in chest, abdomen, post-op regions

Diagnosis Statement
Ineffective breathing pattern related to pain and muscle guarding as evidenced by shallow, rapid respirations and decreased chest expansion.

Goal
- Restore effective, relaxed breathing
- Maintain adequate oxygenation

Planning
- Alleviate pain prior to respiratory effort-intensive activities
- Promote active participation in pulmonary hygiene

Evaluation
- Normal breathing restored, $SaO_2 \geq 94\%$ on RA
- Exhibits regular depth and pattern with decreased splinting

Interventions (≥7)
1. Monitor respiratory status and oxygen saturation at least every shift.
2. Assess pain triggers and provide pain relief before pulmonary exercises and mobilization.
3. Teach and assist with use of incentive spirometer and deep-breathing exercises.
4. Encourage splinting of incisions/cough with pillows to aid cough and expansion.
5. Promote upright positioning and physical mobility as tolerated.
6. Monitor for signs of respiratory distress (tachypnea, cyanosis, confusion).
7. Administer oxygen therapy as needed per order.
8. Refer to respiratory therapy for further assessment and interventions.

15. Risk for Falls

Nursing Assessment
- Assess history and risk factors for falls (age, weakness, gait instability, pain, meds)
- Review use of assistive devices or safety gear
- Evaluate mobility, visual, cognitive, or environmental hazards

Diagnosis Statement
Risk for falls related to pain-impacted mobility, weakness, and sedating analgesic use as evidenced by presence of risk factors.

Goal
- Prevent patient injury related to falls
- Maintain safe environment with risk mitigation

Planning
- Identify high-risk situations/periods and plan enhanced supervision
- Ensure accessibility to assistive devices and monitoring

Evaluation
- No incident falls during hospitalization/care episode
- Patient/family demonstrate understanding of fall prevention strategies

Interventions (≥7)
1. Assess for and document fall risk on admission and at least daily.
2. Orient patient to environment; keep call light and personal items within reach.
3. Encourage use of assistive devices; check for safety and fit.
4. Provide adequate lighting and clear walkways; remove clutter.
5. Instruct on using assistance for transfers/ambulation if needed.
6. Monitor medication effects (sedation, dizziness) and adjust care accordingly.
7. Implement safety measures such as non-slip footwear, bed/chair alarms, and frequent checks.
8. Educate patient and family on fall prevention and seeking help.