**Patient Scenario**

Mrs. Jamison is a 34-year-old woman admitted through the emergency department with kidney stones. As you reposition her in bed, she is visibly grimacing and audibly moaning. She rates her pain at an “8 out of 10” although she reports her pain has “improved” since admission with the IV morphine delivered via PCA pump. You recheck her vital signs and her blood pressure is elevated at 150/90 and her heart rate is 120.

**Applying the Nursing Process**

**Assessment:** The nurse notes that Mrs. Jamison demonstrates signs of discomfort with visible grimacing, audible moaning, and elevated blood pressure and heart rate. She rates her pain at “8 out of 10.”

Based on the assessment information that has been gathered, the following nursing care plan is created for Mrs. Jamison.

**Nursing Diagnosis:** Acute Pain related to physical injury agent as evidenced by change in physiological parameters and self-report of pain rated as “8 out of 10.”

**Overall Goal:** The patient will report that the pain management treatment plan achieves her comfort-function goal.

**SMART Expected Outcomes:**

- Mrs. Jamison will verbalize pain reduction to a self-reported tolerable level of “4” or less on a 0-10 scale by the end of the shift.
Mrs. Jamison’s blood pressure and heart rate will return to baseline levels by the end of the shift.

Planning and Implementing Nursing Interventions:

The nurse will perform a comprehensive pain assessment and identify the patient’s expectation regarding pain management. The nurse will encourage the patient to use breathing techniques and relaxation methods to facilitate pain management. The nurse will notify the provider of unrelieved pain and request additional prescriptions for medication as needed.

Sample Documentation:

Mrs. Jamison was admitted with acute pain related to kidney stones and is receiving Morphine via PCA pump. At 1400, her blood pressure was elevated at 150/90 and her heart rate elevated at 120. She reported pain as an “8 out of 10.” She was visibly grimacing and audibly moaning when repositioned in bed. Dr. Smith was notified at 1400 and a new prescription received. Ketorolac 30 mg IV was administered at 1415. At 1515, the patient stated her pain had decreased to a “3 out of 10” level and this level was “satisfactory.” Her blood pressure also decreased to 135/76 and her heart rate decreased to 88.

Evaluation:

Within one hour of administration of Ketorolac, Mrs. Jamison verbalized pain reduction to her reported satisfactory level of “3,” and her blood pressure and heart rate decreased to her baseline levels. SMART outcomes were “met.”