NURSING CARE PLAN FOR CHOLERA:

Assessment	Nursing Diagnosis	Goal/Expected Outcome	Intervention/Planning	Implementation	Rationale	Evaluation
Subjective Data: **- Patient reports watery diarrhea and severe thirst.** **Objective Data:** **- Blood pressure is low (80/50 mmHg); heart rate is 120 bpm; patient appears dehydrated with dry mucous membranes.**	**Deficient Fluid Volume** related to excessive fluid loss from diarrhea as evidenced by hypotension, tachycardia, and dehydration signs.	**Short-Term:** - Within 30 minutes, patient's blood pressure will improve to at least 100/70 mmHg and heart rate will decrease to < 100 bpm. **Long-Term:** - Maintain normal fluid balance and stable vital signs throughout hospitalization.	Develop a plan to rapidly replace fluids using ORS or IV fluids (normal saline). Monitor vital signs and urine output closely.	Administer IV fluids as per doctor's order; monitor vital signs every 15-30 minutes; adjust fluid rate based on response.	Replenishing fluids helps restore blood volume and improves tissue perfusion, reducing the risk of shock.	Vital signs stabilize; improved urine output; patient reports feeling less thirsty and more comfortable.
Subjective Data: **- Patient complains of abdominal cramps and nausea.** **Objective Data:** **- Observed abdominal tenderness and discomfort on**	**Acute Pain** related to gastrointestinal irritation and cramping as evidenced by patient's report of pain and physical findings.	**Short-Term:** - Within 1 hour, patient's pain score will decrease from 8/10 to 4/10. **Long-Term:** - Patient will experience minimal pain and be able to eat and	Plan for pain management by administering prescribed analgesics and applying comfort measures (warm compresses).	Administer analgesics as ordered; apply a warm compress to the abdomen; re-assess pain every 30 minutes.	Managing pain improves comfort and allows the patient to relax, aiding recovery.	Patient's pain score decreases; comfort increases; patient is able to tolerate oral intake better.

palpation; patient appears uncomfortable.		drink without discomfort.				
Subjective Data: **- Patient feels weak and dizzy, especially when standing.** **Objective Data:** **- Signs of low blood volume; dizziness on standing; reduced skin turgor.**	**Risk for Injury** related to dehydration and weakness as evidenced by dizziness and impaired physical function.	**Short-Term:** - Within 30 minutes, reduce episodes of dizziness and improve patient safety. **Long-Term:** - Patient will remain safe while moving and show no signs of injury.	Plan to ensure safe positioning and assist with mobility. Educate patient on rising slowly from bed or chair.	Assist the patient in moving from a lying to a sitting position slowly; use assistive devices if needed; monitor for signs of dizziness during movement.	Safe mobility practices help prevent falls and injuries, especially in dehydrated patients.	Patient reports less dizziness when moving; no falls or injuries occur; patient demonstrates proper techniques for safe movement.