NURSING CARE PLAN FOR LAPAROTOMY

Assessment	Nursing Diagnosis	Goal/Expected Outcome	Intervention/Planning	Implementation	Rationale	Evaluation
Patient reports severe pain at the incision site with facial grimacing; vital signs indicate tachycardia.	Acute Pain related to surgical incision and tissue trauma as evidenced by pain rating of 8/10.	Patient will report pain reduction to 4/10 within 24 hours after interventions.	Administer analgesics as prescribed; provide non-pharmacologic pain relief such as guided imagery.	Administer scheduled pain medications and coach patient through a relaxation exercise.	Effective pain management facilitates recovery and encourages mobility.	Patient reports decreased pain and exhibits reduced signs of distress.
Patient exhibits shallow breathing and reduced lung expansion postoperatively.	Ineffective Airway Clearance related to pain and anesthesia effects as evidenced by decreased respiratory rate and shallow breathing.	Patient will perform deep breathing and coughing exercises independently by postoperative day 2.	Educate patient on the use of incentive spirometry; demonstrate deep breathing techniques.	Provide an incentive spirometer and assist the patient in performing exercises every 2 hours.	Deep breathing exercises prevent atelectasis and improve oxygenation.	Patient demonstrates correct use of incentive spirometer and improved respiratory function.
Patient shows absence of bowel sounds and complaints of abdominal bloating on	Impaired Gastrointestinal Function related to postoperative ileus as evidenced by	Patient will have the return of bowel function (bowel sounds and passage of	Monitor bowel sounds; gradually reintroduce oral intake starting with clear liquids, then soft diet.	Document bowel sounds every 4 hours; advance diet as tolerated.	Gradual dietary advancement prevents overload of the recovering	Bowel sounds return and the patient successfully tolerates a soft diet.

postoperative day 1.	absent bowel sounds and abdominal discomfort.	flatus) within 48 hours.			digestive system.	
Patient’s surgical site shows mild redness and swelling but no discharge.	Risk for Infection related to surgical wound as evidenced by postoperative wound changes.	Patient will remain free from infection as evidenced by stable vital signs and absence of purulent discharge.	Perform regular wound care; educate the patient on proper hygiene and signs of infection.	Clean and dress the wound per protocol; instruct patient on hand hygiene.	Early detection and proper wound care reduce the risk of infection.	Wound condition improves without signs of infection; vital signs remain stable.
Patient experiences fatigue and limited mobility after surgery.	Risk for Impaired Mobility related to postoperative pain and fatigue as evidenced by decreased activity levels.	Patient will gradually increase mobility and perform activities of daily living with minimal assistance by postoperative day 3.	Encourage early ambulation; assist with gradual mobilization and provide energy conservation techniques.	Help the patient sit up, dangle legs, and walk short distances as tolerated; use support devices if needed.	Early mobilization prevents complications such as deep vein thrombosis and promotes faster recovery.	Patient demonstrates increased activity and improved functional mobility.