NURSING CARE PLAN FOR PERICARDITIS:

Assessment	Nursing Diagnosis	Goal/Expected Outcome	Intervention/Planning	Implementation	Rationale	Evaluation
Subjective Data: - Patient reports sharp chest pain that worsens when lying down. Objective Data: - ECG shows abnormal rhythms; blood pressure is slightly low; patient appears fatigued.	Decreased Cardiac Output related to pericardial inflammation as evidenced by chest pain, abnormal ECG, and fatigue.	Short-Term: - Within 1 hour, reduce chest pain and stabilize heart rate. Long-Term: - Patient maintains improved cardiac output and regular heart rhythm.	Administer prescribed anti- inflammatory medications and analgesics; monitor ECG continuously.	Deliver medications as ordered; reassess vital signs and ECG every 15-30 minutes; document changes.	Anti- inflammatory treatment reduces pericardial inflammation, improving cardiac function.	ECG normalizes; chest pain decreases; patient reports increased comfort.
Subjective Data: - Patient expresses concern about managing symptoms at home. Objective Data:	Deficient Knowledge regarding pericarditis management as evidenced by patient	Short-Term: - Within 24 hours, patient verbalizes key self-care strategies. Long-Term: - Patient adheres to the care plan and attends	Develop a detailed education plan on pericarditis, including medication use, activity guidelines, and warning signs.	Conduct individual teaching sessions; provide written materials and visual aids; schedule regular follow-ups.	Education empowers patients to manage their condition and reduces anxiety.	Patient demonstrates increased understanding; adherence improves; follow- up confirms consistency.

- Patient asks	uncertainty and	follow-up		
questions	anxiety.	appointments		
about self-care;		consistently.		
signs of anxiety				
observed.				

MMM. NursingExpert.in