NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	INFERENCE	PLANNING	INTERVENTION	RATIONALE	EVALUATION
Subjective: "Masakit ang tiyan ko" (*My tummy hurts*) as verbalized by patient. Objective: • Facial mask of pain. • Guarding behavior. • V/S taken as follows: T: 36.4 P: 85 R: 22 Bp: 110/90	• Acute pain related to distention or rupture of fallopian tube.	• Ectopic pregnancy is gestation located outside the uterine cavity. The fertilized ovum implants outside of the uterus, usually in the fallopian tube. Predisposing factors include adhesions of the tube , salpingitis, congenital and developmental anomalies of the fallopian tube, previous ectopic pregnancy,	• After 8 hours of nursing interventions , the patient will be relieved or controlled.	Independent: • Monitor maternal vital signs. • Monitor for presence and amount of vaginal bleeding. • Monitor for increase and pain and abdominal distention and rigidity. • Monitor complete blood count (CBC). • Provide comfort measure like back rubs, deep breathing. Instruct in relaxation or visualization exercises. Provide diversional activities. • Provide diversional	• To determine presence of hypotension and tachycardia caused by rupture or hemorrhage. • To further assess the present situation indicating hemorrhage. • Increased pain and abdominal distention indicates rupture and possible intra-abdominal hemorrhage. • To determine the amount of blood loss. • Promotes relaxation and may enhance patient's coping abilities by refocusing attention. • Diversional activities aids in	• After 8 hours of nursing interventions, the patient was relieved or controlled.

		use of an intrauterine device for more than 2 years, multiple induced abortions, menstrual reflux , and decreased tubal motility.		activities. Collaborative: • Administer analgesics as indicated.	refocusing attention and enhancing coping with limitations. • To maintain acceptable level of pain.	