NURSING CARE PLAN
(SOMATIC SYMPTOM DISORDER - SSD)

Medical Diagnosis: Somatic Symptom Disorder (SSD)		
Subjective Data:	**Nursing Intervention (ADPIE)**	**Rationale**
• Pain • Fatigue • Shortness of breath • Nausea • Chest pain • Vision problems • Amnesia • Food intolerance • Sexual dysfunction • Headaches • Anxiety • Dysphagia	Perform complete nursing assessment with vital signs	Get baseline information and determine if there is a physical or explained cause of symptoms.
	Assess pain per appropriate scale	Pain is subjective and must be managed according to what the client feels and reports.
	Discuss symptoms with client and when they began, what makes them better or worse and how they have been managing these symptoms	This helps make a more definitive diagnosis and help determine how to best treat client. Helping the client determine the etiology of symptoms helps them to recognize and avoid situations that make symptoms worse.
Objective Data: • Unremarkable imaging (X-ray, CT, MRI, ultrasound) • Lab tests are WNL • Vomiting • Paralysis	Discuss signs and symptoms and what triggers those symptoms	Help the family to be aware and understand the reality of the client's condition. This can be helpful in long-term management if client's family is willing to provide realistic feedback and support.
	Assess if client is having suicidal or homicidal ideations or potential substance abuse	Maintain client's safety and the safety of others
	Provide teaching and demonstrations of relaxation techniques including progressive muscle relaxation and deep breathing exercise	This can help relieve acute pain and distress that the client may feel, but also helps them learn to control many symptoms through focus and calming the mind.

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