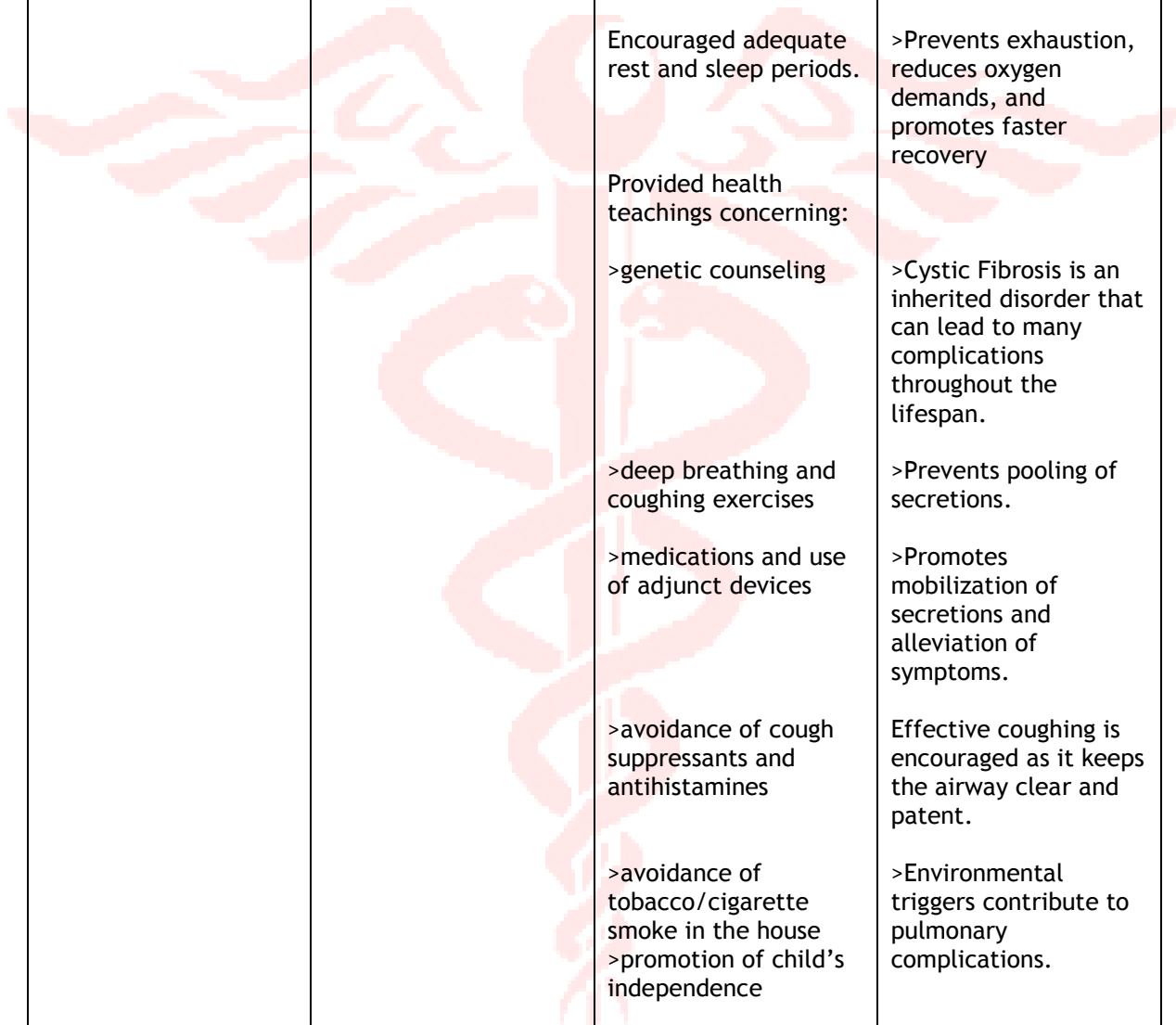


NURSING CARE PLAN

ASSESSMENT	NURSING DIAGNOSIS	PLANNING	NURSING INTERVENTION	RATIONALE	EVALUATION / OUTCOME
<p>Subjective Cues:</p> <p>>Patient states, "My chest feels heavy when I cough."</p> <p>Objective Cues:</p> <p>>open-mouthed breathing</p> <p>>nasal flaring</p> <p>>restlessness</p> <p>>rales and wheezes heard upon auscultation</p> <p>>shallow, rapid respirations (RR not within N range for child's age)</p> <p>>ineffective cough</p> <p>>activity intolerance</p> <p>>clubbing of fingers</p> <p>>PaCO₂=60mm HG</p>	<p>Ineffective Airway Clearance related to excessive mucus production secondary to cystic fibrosis</p> <p>(Cystic Fibrosis is a disease in which there is a generalized dysfunction of the exocrine glands. Mucus secretions, such as in the lungs, have difficulty flowing through gland ducts leading to pooling of secretions and often resulting to pulmonary complications.)</p>	<p>Within 8 hours, patient will maintain patent airway as evidenced by:</p> <p>>clear breath sounds</p> <p>>RR within N range</p> <p>>PaO₂ , 80 to 90 mmHG; PCO₂, 40 mmHG</p> <p>>effective expectoration of secretions</p> <p>>demonstration of deep breathing and coughing exercises as instructed</p>	<p>Independent:</p> <p>Noted and documented changes in patient's respiratory status and vital signs.</p> <p>Monitored patient's respiratory status at least every 4 hours.</p> <p>Placed patient in a semi - or high-Fowler's position.</p> <p>Provided aerosol treatments such as handheld nebulizers and mist tent as needed.</p> <p>Provided supplemental oxygenation as needed.</p> <p>Encouraged patient to increase fluid intake as tolerated.</p> <p>Provided oral hygiene on a regular basis using a soft toothbrush and good-tasting mouthwash.</p>	<p>>Assessment provides baseline data to evaluate efficacy of nursing interventions rendered.</p> <p>>Continuous monitoring of patient's status facilitates early detection of complications</p> <p>>Promotes maximum chest expansion for ventilation.</p> <p>>Promotes ventilation and air flow by liquefying and facilitating removal of secretions.</p> <p>>Oxygen supplementation is administered to keep PaO₂ levels above 60 mmHG</p> <p>>Adequate fluid intake helps lessen viscosity of secretions.</p> <p>>Frequent oral hygiene is necessary to remove the disagreeable taste and odor of sputum.</p>	<p>Goal Met. The patient's airway remained patent as evidenced by:</p> <p>>clear breath sounds</p> <p>>RR within N range</p> <p>>PaO₂, 90 mmHG; PCO₂, 45 mmHG</p> <p>>ability to effectively expectorate secretions</p> <p>>demonstration of effective deep breathing and coughing techniques</p>



>Administered expectorants and mucolytics as ordered.

Collaborative:

>Collaborated with physician and /or respiratory therapist on the patient's need for chest physiotherapy and other supportive equipment (e.g. incentive spirometer).

>Monitored serial xrays/ABG/pulse oximetry readings.

>Provide referrals to support groups/community agencies/available resources especially on education during extended hospitalization

>Helps mobilize secretions.

>Percussion and postural drainage is performed at least q 6 hours. Adjunctive therapy may be necessary to mobilize secretions.

>Continuous monitoring facilitates early detection of complications.

>Providing referrals will help parents/significant others in managing patient's illness and promotes adjustment to the long-term stress of a chronic illness.

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