

# NURSING CARE PLAN FOR AMANDA AQUILINI

**NURSING DIAGNOSIS: *INEFFECTIVE AIRWAY CLEARANCE* RELATED TO VISCOUS SECRETIONS AND SHALLOW CHEST EXPANSION SECONDARY TO FLUID VOLUME DEFICIT, PAIN, AND FATIGUE**

## GOALS [NOC#]/ DESIRED OUTCOMES

## NURSING ORDERS

## RATIONALE

Respiratory Status: Gas exchange [0402], as evidenced by

- Absence of pallor and cyanosis (skin and mucous membranes)
- Use of correct breathing/ coughing technique after instruction
- Productive cough
- Symmetric chest excursion of at least 4 cm

Within 48-72 hours

- Lungs clear to auscultation
- Respirations 12-22/min; pulse, 100 beats/min
- Inhales normal volume of air on incentive spirometer

Monitor respiratory status q4h: rate, depth, effort, skin color, mucous membranes, amount and color of sputum.  
 Monitor results of blood gases, chest x-ray studies, and incentive spirometer volume as available.  
 Monitor level of consciousness.  
 Auscultate lungs q4h.  
 Vital signs q4h (TPR, BP, pulse oximetry).

Instruct in breathing and coughing techniques. Remind to perform, and assist q3h.

Administer prescribed expectorant; schedule for maximum effectiveness.

Maintain Fowler's or semi-Fowler's position.

Administer prescribed analgesics. Notify physician if pain not relieved.

Administer oxygen by nasal cannula as prescribed. Provide portable oxygen if client goes off unit (e.g., for x-ray examination).

Assist with postural drainage daily at 0930.  
 Administer prescribed antibiotic to maintain constant blood level.  
 Observe for rash and GI or other side effects.

To identify progress toward or deviations from goal. *Ineffective Airway Clearance* leads to poor oxygenation, as evidenced by pallor, cyanosis, lethargy, and drowsiness.

Inadequate oxygenation causes increased pulse rate. Respiratory rate may be decreased by narcotic analgesics. Shallow breathing further compromises oxygenation.

To enable client to cough up secretions. May need encouragement and support because of fatigue and pain.

Helps loosen secretions so they can be coughed up and expelled.

Gravity allows for fuller lung expansion by decreasing pressure of abdomen on diaphragm.

Controls pleuritic pain by blocking pain pathways and altering perception of pain, enabling client to increase thoracic expansion. Unrelieved pain may signal impending complication.

Supplemental oxygen makes more oxygen available to the cells, even though less air is being moved by the client, thereby reducing the work of breathing.

Gravity facilitates movement of secretions upward through the respiratory passage. Resolves infection by bacteriostatic or bactericidal effect, depending on type of antibiotic used. Constant level required to prevent pathogens from multiplying. Allergies to antibiotics are common.

# NURSING CARE PLAN FOR AMANDA AQUILINI *continued*

## NURSING DIAGNOSIS: DEFICIENT FLUID VOLUME: INTAKE INSUFFICIENT TO REPLACE FLUID LOSS

(See standardized care plan for *Deficient Fluid Volume*, Figure 18–4). Nursing Diagnosis: *Anxiety* related to difficulty breathing and concern about work and parenting roles.

GOALS/DESIRED OUTCOMES	NURSING ORDERS	RATIONALE
<p>Anxiety control [1402], as evidenced by</p> <ul style="list-style-type: none"> <li>Listening to and following instructions for correct breathing and coughing technique, even during periods of dyspnea</li> </ul>	<p>When client is dyspneic, stay with her; reassure her you will stay.</p>	<p>Presence of a competent caregiver reduces fear of being unable to breathe. Control of anxiety will help client to maintain effective breathing pattern.</p>
<ul style="list-style-type: none"> <li>Verbalizing understanding of condition, diagnostic tests, and treatments (by end of day)</li> </ul>	<p>Remain calm; appear confident. Encourage slow, deep breathing.</p>	<p>Reassures client the nurse can help her. Focusing on breathing may help client feel in control and decrease anxiety.</p>
<ul style="list-style-type: none"> <li>Decrease in reports of fear and anxiety</li> <li>Voice steady, not shaky</li> <li>Respiratory rate of 12–22/min</li> </ul>	<p>When client is dyspneic, give brief explanations of treatments and procedures. When acute episode is over, give detailed information about nature of condition, treatments, and tests.</p>	<p>Anxiety and pain interfere with learning. Knowing what to expect reduces anxiety.</p>
<ul style="list-style-type: none"> <li>Freely expressing concerns and possible solutions about work and parenting roles. Explore alternatives as needed. Note whether husband returns as scheduled. If not, institute care plan for actual <i>Interrupted Family Processes</i></li> </ul>	<p>As client can tolerate, encourage to express and expand on her concerns about her child and her work.</p>	<p>Awareness of source of anxiety enables client to gain control over it. Husband’s continued absence would constitute a defining characteristic for this nursing diagnosis.</p>