

Assessment	Nursing Diagnosis	Planning			Implementation	Evaluation
		Objective of Care	Intervention	Rationale		
Subjective cues - The SO verbalized "Mehinapari si Mana hainaga kati naya plane." Objective cues - Restless - Dyspnea - BP: 154/97 mmHg - RR: 27 breath/min - PR: 97 bpm - O₂sat: 97%	<i>Ineffective airway clearance related to retained secretions as evidenced by dyspnea, alteration in respiratory rate and restless</i>	After 10hrs of Nursing intervention, the client will be able to, - Maintain airway patency - Expectorate/clear secretions readily.	- Position head appropriately for age and condition. - Monitor respirations and breath sounds, noting rate and sounds (e.g., tachypnea, crackles, wheezes). - Suction nose, mouth, and trachea per using correct-size catheter and suction timing for adult. - Exercise diligence in providing oral hygiene and keeping oral mucosa hydrated.	- To open or maintain open airway in an alert or compromised individual. - Indicative of respiratory distress and/or accumulation of secretions. - To clear airway when excessive or viscous secretions are blocking airway or client is unable to swallow or cough effectively. - Airways can be obstructed by substances such as blood or thickened secretions. These can be managed by strict attention to good oral hygiene, especially in the client who is unable to provide that for self.	- Positioned the client according to her condition. - Noted client respirations, breath sounds and rate. - Assisted in suctioning and used appropriate catheter. - Provided client with oral hygiene and kept oral mucosa hydrated after suction.	After 10hrs of Nursing intervention, the client was able to, - Maintain a patent airway as evidenced by vital signs: - RR: 18bpm - O₂sat: 97% - Expectorate secretions upon suctioning with appropriate catheter. - Demonstrate behaviors of clear airway as evidenced by absence of tachypnea and dyspnea.

Micu Nursing Guide

Peipei Pang



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