

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) CHART

Nursing Diagnosis	Goal	Intervention	Rationale	Evaluation
#1 - Insufficient airway clearance related to increase mucus production as evidenced by profuse coughing and forced breathing.	Maintain clear airway by effective coughing.	<ul style="list-style-type: none"> i. Access lung sound at least every 4 hours. ii. Monitor amount, color and consistency of sputum. iii. Proper position should be provided i.e. fowler's/semi fowler's position to prevent aspiration of secretions. iv. Provide adequate oral fluid if indicated, if not then IV fluid may be provided as per physician's order. v. Encourage patient to cough and deep breath vi. Administer expectorants and antibiotic as ordered. vii. If patient is unable to cough up secretions, suction should perform as per prescription. viii. Request for chest physiotherapy as per physician's order. 	<ul style="list-style-type: none"> i. Wheezes and crackle sound may indicate excess secretions in airway. ii. Thick purulent sputum indicates infection. iii. Movement mobilizes secretion and helps in breath properly. iv. Hydration decreases viscosity of secretion. v. Controlled coughing and deep breathe is more effective for clearing airway. vi. To liquefy secretion and trigger cough reflex. vii. Suction is necessary to remove secretions and clear airway. viii. To mobilize secretions. 	<ul style="list-style-type: none"> i. Does lung sound indicate retained secretion? ii. Does sputum indicates infection? iii. Is patient mobile? iv. Are secretions thin and easily expectorated? v. Does patient cough and breathe effectively? vi. Are medications effective? vii. Is patient feeling comfortable after suctioning? viii. Is physiotherapy is well tolerated by the patient?

<p>#2- ineffective breathing patterns related to shortness of breath and airway irritation as evidenced by high respiratory rate.</p>	<p>Patient should maintain an effective breathing pattern i.e. respiratory rate in between 12 to 24 per minute.</p>	<ul style="list-style-type: none"> i. Access respiratory rate, depth and rhythm. ii. Monitor blood gas and oxygen saturation value. iii. Place patient in fowlers or Semi fowler's position. iv. Diaphragmatic breathing training/ deep breathing training should be given to patient. v. Administer oxygen as prescribed. 	<ul style="list-style-type: none"> i. Respiration less than 12 and more than 24 may indicate an ineffective pattern. ii. An ineffective breathing pattern will not maintain oxygenation. iii. This allows for maximum chest expansion. iv. Breathing exercise promotes relaxation and CO₂ excretion. v. To maintain optimal cellular function. 	<ul style="list-style-type: none"> i. Is respiratory pattern ineffective? ii. Is breathing pattern adversely affecting oxygenation? iii. Is patient comfortable in this position? iv. Is patient able to demonstrate an effective breathing pattern? v. Is oxygen administration restored normal breathing pattern?
<p>#3 – impaired gas exchange related to decrease ventilation or perfusion as evidenced by headache, restlessness and improving ABG.</p>	<p>The patient will experience improved gas exchange.</p>	<ul style="list-style-type: none"> i. Access lung sound, respiratory rate and effort, use of accessory muscles. ii. Observe skin and mucus membrane for cyanosis. iii. Access degree of dyspnea on scale of 0 to 10, 0 = no dyspnea, 10 = worst dyspnea. iv. Monitor for confusion and change in mental status. v. Monitor ABG value and pulse oxymetry as ordered. vi. Elevate head of bed or help patient to lean on over bet table. 	<ul style="list-style-type: none"> i. Respiratory rate less than 12 or more than 24 or use of accessory muscles indicates distress. Diminished lung sound indicates poor air movement and impaired gas exchange. ii. Cyanosis indicates poor oxygenation. Oral mucus cyanosis indicates serous hypoxia. iii. The patient's subjective report is the best measure of dyspnea. iv. Change in mental status can signal impaired gas exchange. v. PaO₂ < 80 mmHg, PaCO₂ > 45 mmHg or SaO₂ < 90 indicate impaired 	<ul style="list-style-type: none"> i. Are lung sounds clear and audible? Is respiratory rate 12 to 24/min? ii. Are skin and mucus membrane pink? iii. Is patient's degree of dyspnea within parameters that are acceptable to patient? iv. Is patient alert and oriented? v. Are values within patient's base line value? vi. Did change of position relieve some distress? vii. Does oxygen provide relief from dyspnea? viii. Do breathing exercises help?

		<ul style="list-style-type: none"> vii. Administer supplemental oxygen at $\leq 2L$ per minute if ordered. viii. Teach patient relaxation exercise, diaphragmatic (deep) and pursed lip breathing (a breathing technique that consist of exhaling through tightly pressed lip & inhaling through the nose with closed mouth). ix. Encourage patient to stop smoking. x. For severe dyspnea, ask physician about an order for intravenous morphine sulfate. 	<ul style="list-style-type: none"> gas exchange. vi. Upright position promotes lung expansion. vii. Supplemental oxygen decreases hypoxia. viii. Relaxation exercise and breathing exercise decrease perceived dyspnea and promote relaxation with increase CO_2 excretion. ix. Smoking is damaging to lungs and respiratory function. x. Low doses of IV Morphine cause vasodilation which helps relieve pulmonary edema and anxiety. 	<ul style="list-style-type: none"> ix. Does it have any impact on client? x. Does morphine provide relief from dyspnea?
<p>#4 – Altered nutrition less than body requirement related to reduce appetite as evidenced by poor muscle tone and lack of interest in food.</p>	<p>Patient should have normal body weight.</p>	<ul style="list-style-type: none"> i. Assess dietary habit & recent food intake. ii. Auscultate bowel sound. iii. Give frequent oral care & remove expectorated secretions. iv. Encourage a rest period of 1 hour before and after meal. v. Provide frequent and small feeding. vi. Avoid gas producing food and 	<ul style="list-style-type: none"> i. Respiratory distress is often anorectic because of dyspnea, sputum production and medication effect. As a result client often admitted with some degree of malnutrition. ii. Diminished or hypoactive bowel sounds may reflect decreased gastric motility and constipation related to limited 	<ul style="list-style-type: none"> i. Is any impact of dietary habit due to respiratory distress observed? ii. Is any deviation of bowel sound detected? iii. Is patient feeling better after removal of secretions? iv. Is 1 hour gap before and after meal is effective?

		<p>carbonated beverages.</p> <p>vii. Avoid very hot and very cold food.</p> <p>viii. Weight, as indicated.</p> <p>ix. Consult dietitian or nutritional support team to provide easily digested nutritionally balanced meals by mouth if patient can take orally.</p> <p>x. If not then any supplemental or tube feeding and parental nutrition must be provided.</p>	<p>fluid intake, decrease activity and hypoxia.</p> <p>iii. Noxious tastes, smells and sights can reduce appetite and can produce nausea and vomiting with increased respiratory difficulties.</p> <p>iv. Helps reduce fatigue in meal time and provide opportunities to increase total calorie intake.</p> <p>v. May help in enhance intake and easy digestion even though appetite is slow.</p> <p>vi. Can produce abdominal distention.</p> <p>vii. Extreme in temperature can precipitate coughing spasm.</p> <p>viii. Useful in determining caloric needs, setting weight goal & evaluating adequacy of nutritional plan.</p> <p>ix. Methods of feeding and caloric requirements are based on individual's situation and specific need to provide maximum nutrients.</p>	<p>v. Does frequent and small feeding helps in food intake pattern?</p> <p>vi. Is patient feeling good and no abdominal distention is there?</p> <p>vii. Does it have any impact on patient's cough reflex?</p> <p>viii. Is patient maintaining the normal caloric need?</p> <p>ix. Does patient take oral feeding? Does nutritional plan works?</p>
#5 – Activity intolerance	The patient will accomplish	i. Evaluate client's response to activity.	i. Establish client's capabilities and	i. Is any dyspnea and weakness

<p>related to ineffective breathing pattern as evidenced by fatigue and abnormal heart rate response to activity.</p>	<p>activities of daily living without dyspnea or excessive fatigue.</p>	<p>Note reports of dyspnea, increase weakness and fatigue & changes in vital signs during and after activities.</p> <ul style="list-style-type: none"> ii. Provide a quiet environment and limit visitors during acute phase and encourage use of stress management and diversional activities. iii. Explain importance of rest in treatment plan and necessity of balancing activities with rest. iv. Assist client to assume comfortable position for rest and sleep. v. Assists with self-care activities as necessary. 	<p>need.</p> <ul style="list-style-type: none"> ii. Reduce stress and excess stimulation & promote rest. iii. Minimizes exertion and helps in balancing oxygen supply and demand. iv. Will help the patient to reduce exertion. v. Reduce client's effort and maintains normal heart rate and breathing. 	<p>identified?</p> <ul style="list-style-type: none"> ii. Are stress management and diversional activities helpful? iii. What is the condition of the client after balanced activity and rest? iv. After positioning does the patient feels good? v. What is the impact of this on client's exertion and heart rate?
<p>#6 – Risk for infection related to the chronic disease condition.</p>	<p>To prevent and reduce risk and spread of secondary infection.</p>	<ul style="list-style-type: none"> i. Monitor vital sign, sputum color and body temperature. ii. Encourage fluid intake. iii. Protect patient from people with respiratory infections and limit visitors as indicated. iv. Demonstrate and encourage hand washing technique. v. Change position frequently. vi. Promote adequate nutritional intake. vii. Investigate sudden changes and deterioration in condition such as increasing chest 	<ul style="list-style-type: none"> i. During this period potentially fatal complication such as hypertension and shock may develop. ii. Hydration decreases viscosity of secretion. iii. Effective means of reducing spread of infection. iv. Best way to avoid and reduce infection. v. Improves respiratory function and releases pressure from pressure points. vi. Minimizes the risk of unusual weight loss and provide 	<ul style="list-style-type: none"> i. Does vital sign and sputum color indicate any complication? ii. What is the consistency of secretion now? iii. What is the breathing rate of the client after limiting visitors? iv. Are client and family members following hand washing technique? v. Is client comfortable with changing position? vi. Is client taking adequate

		<ul style="list-style-type: none"> iii. pain, recurring fever and changes in sputum characteristics. Administer antimicrobial as prescribed. 	<ul style="list-style-type: none"> ii. adequate energy, hence improve pulmonary status. Helps in early detection and treatment of secondary infections. iii. Reduce infectious pathogens. 	<ul style="list-style-type: none"> ii. nutrition? Does client feel any deterioration in health condition? iii. Is patient getting antimicrobial regularly and timely?
#7 - -deficient knowledge of self-care strategies related to lack of exposure as evidenced by inaccurate follow through of instruction.	Client will understand the condition, disease process and prognosis and will initiate necessary life style changes & participate in treatment program.	<ul style="list-style-type: none"> i. Provide information in written and verbal form. ii. Emphasize importance of continuing effective coughing and deep breathing exercises. iii. Assist patient to identify ways to incorporate changes related to illness and its treatment into lifestyle. iv. Explain importance of cessation of smoking. 	<ul style="list-style-type: none"> i. Provides patient with information that can be used for further clarification at home. ii. It relieves dyspnea, increasing strength and endurance of the respiratory muscles, and optimizing the pattern of thoraco-abdominal motion. iii. Patient can see that his or her life does not have to revolve around the disease. iv. Smoking cessation enables loss of breath to be stabilized, and reduces the frequency of coughing and expectoration. 	<ul style="list-style-type: none"> i. Is this method helpful to client and its family members? ii. Does client understand the effectiveness of coughing and deep breathing exercise? iii. Does this give psychological support to the client? iv. Does this have any impact on client?