Nursing Care Plan - Chronic Obstructive Pulmonary Disease (COPD)

Assessment	Nursing Diagnosis	Goals/Outcome Criteria	Interventions	Rationale	Evaluation	Documentation
Subjective: “Nahihirapan ako huminga” as verbalized by the patient. Objective: • Use of accessory muscles • Dyspnea • Productive cough • V/S: T: 36.7, P: 57, R: 25, BP: 100/80	• Ineffective airway clearance related to increased production of secretions as evidenced by dyspnea, productive cough, and use of accessory muscles.	• After 4 hours of nursing interventions, the patient will demonstrate effective airway clearance as evidenced by improved breathing pattern, effective cough, and expectoration of secretions.	**Independent:** • Assist patient in assuming a comfortable position (elevate head of bed, overbed table support). • Encourage pursed-lip breathing and effective coughing techniques. • Minimize environmental triggers (dust, smoke, allergens). **Dependent:** • Administer prescribed bronchodilators and expectorants. • Provide nebulization as ordered.	• Elevating the head of the bed reduces pressure on the lungs and improves airflow. • Pursed-lip breathing helps slow respiratory rate and prevent airway collapse. • Nebulization moistens airways, loosens secretions, and improves expectoration.	• After 4 hours of interventions, the patient demonstrated improved airway clearance as evidenced by effective coughing, decreased dyspnea, and normal respiratory effort.	• Documented patient's response to interventions, changes in respiratory status, effectiveness of medications, and patient’s ability to clear secretions independently.