

# CROUP NURSING CARE PLANS

Nursing Diagnosis	Patient Goals/Expected Outcomes	Assessment Data	Nursing Interventions	Rationale	Evaluation	Documentation/Follow-Up
<b>Ineffective Airway Clearance</b>	Patient will demonstrate clear airway and reduced stridor within 24 hours	Presence of stridor; audible wheezing; increased respiratory effort	Administer nebulized epinephrine; encourage coughing; perform chest physiotherapy as ordered	Relieves airway obstruction and improves oxygenation	Stridor reduced; clearer lung sounds observed	Document respiratory assessments and medication effects
<b>Impaired Breathing Pattern</b>	Stabilize respiratory rate and oxygen saturation within 48 hours	Elevated respiratory rate; decreased oxygen saturation	Provide supplemental oxygen; monitor oxygen saturation continuously; adjust positioning to optimize breathing	Enhances gas exchange and reduces respiratory distress	Stable respiratory rate and oxygen levels maintained	Record vital signs and respiratory assessments
<b>Acute Pain</b>	Patient will exhibit reduced pain ( $\leq 3/10$ ) within 24 hours	Reports of throat pain; persistent cough causing discomfort	Administer prescribed analgesics; use non-pharmacological pain relief techniques such as distraction or relaxation	Alleviates pain to improve comfort and facilitate effective breathing	Patient reports decreased pain; improved comfort noted	Document pain scores and intervention responses

<b>Anxiety</b>	Patient and caregivers will report reduced anxiety within 24 hours	Patient appears agitated; caregivers express concern	Provide emotional support; explain procedures clearly; offer reassurance and relaxation techniques	Reduces stress and fosters a calm environment	Reduced anxiety observed; positive verbal feedback	Record emotional support interventions and caregiver feedback
<b>Risk for Ineffective Coping</b>	Caregivers will demonstrate effective coping strategies and understanding of the care plan within 24 hours	Caregivers exhibit signs of stress and uncertainty	Educate caregivers on disease process, treatment plan, and home care; provide resource materials and support group information	Empowers caregivers and improves adherence to treatment	Caregivers verbalize understanding and exhibit improved coping behaviors	Document education sessions and follow-up evaluations
<b>Knowledge Deficit</b>	Family will articulate the care plan and home care instructions within 24 hours	Family asks questions about management and signs of deterioration	Distribute written materials; conduct one-on-one teaching sessions; review key points and answer questions	Enhances understanding and ensures compliance with the care plan	Family demonstrates improved comprehension during return explanations	Record teaching sessions and verify comprehension