NURSING DIAGNOSIS: **INEFFECTIVE AIRWAY CLEARANCE**		Patient's Medical Diagnosis:
DEFINITION:	A state in which an individual is unable to clear secretions or obstructions from the respiratory tract to maintain airway patency.	
DEFINING CHARACTERISTICS:	Subjective: Statement of difficulty breathing. Objective: Abnormal breath sounds: rales (crackles), rhonchi, wheezes; changes in rate or depth of respiration; tachypnea; cough, effective or ineffective, with or without sputum; cyanosis; dyspnea; apnea; fear, anxiety, restlessness; use of accessory muscles for breathing; choking or noisy respirations.	
RELATED FACTORS:	Tracheobronchial infection, obstruction, secretion; decreased energy/fatigue; perceptual/cognitive impairment; trauma; inhalation injury.	
STUDENT INSTRUCTIONS:	In the space below enter the subjective and objective data gathered during your patient assessment.	
ASSESSMENT	***Subjective Data Entry***	***Objective Data Entry***
	TIME OUT!	**Student Instructions:** To be sure your patient diagnostic statement written below is accurate, you need to review the defining characteristics and related factors associated with the nursing diagnosis and see how your patient data matches. Do you have an accurate match or is additional data required or does another nursing diagnosis need to be investigated?
DIAGNOSIS	**PATIENT DIAGNOSTIC STATEMENT:**	**Nursing Diagnosis:** _____ **Related to:** _____ **AEB:** _____

PLANNING

Desired Outcome And Patient Criteria: The Patient Will:

TIME OUT! The desired outcome must meet criteria to be accurate. The outcome must be specific, realistic, measurable, and include a time frame for completion. Does the action verb describe the patient's behavior to be evaluated? Can the outcome be used in the evaluation step of the nursing process to measure the patient's response to the nursing interventions listed below?

Interventions	***Rationale For Selected Intervention and References***

EVALUATION

TIME OUT! Do your interventions assist in achieving the desired outcome? Do your interventions address further monitoring of the patient's response to your interventions and to the achievement of the desired outcome? Are qualifiers: **when, how, amount, time,** and **frequency** used? Is the focus of the action's verb on the nurse's actions and not on the patient? Do your rationales provide sufficient reason and directions?

What was your patient's response to the interventions?

Was the desired outcome achieved? If no, what revisions to either the desired outcome or interventions would you make?

☐ Yes ☐ No

DOCUMENTATION

Documentation Focus: Now that you have completed the evaluation, the next step is to document your care and the patient's response. Use the areas below to enter your progress note information.