NANDA Nursing Care Plan

Patient Information

Name: Mrs. Jane Smith Age: 68

Medical History: Hypertension, Type 2 Diabetes

Diagnoses/Conditions: Acute Respiratory Distress Syndrome (ARDS)

Nursing Diagnosis

Problem Statement:

Impaired Gas Exchange related to ventilation-perfusion imbalance and decreased lung compliance.

Etiology/Related Factors:

Increased respiratory rate (28 breaths/minute), decreased oxygen saturation (90%), and bilateral lung infiltrates on chest X-ray

Defining Characteristics:

Shortness of breath, use of accessory muscles for breathing, diminished breath sounds on auscultation.

Goals and Expected Outcomes

Short-Term Goal:

The patient will maintain oxygen saturation above 95% within the next 24 hours.

Long-Term Goal:

The patient will demonstrate improved respiratory function and independence in self-care activities within one week.

Nursing Interventions

Intervention 1:

Administer supplemental oxygen at 3 liters per minute via nasal cannula.

Intervention 2:

Assist the patient in practicing deep-breathing exercises every 2 hours.

Intervention 3:

Administer prescribed nebulizer treatments as ordered.

Rationale

Supplemental oxygen will improve oxygenation, alleviate respiratory distress, and enhance gas exchange. Deep breathing exercises promote lung expansion, improving ventilation. Nebulizer treatments will assist in bronchodilation and secretion clearance.

Evaluation

Criteria for Evaluation:

Respiratory rate within the normal range (12-20 breaths/minute), oxygen saturation consistently above 95%

Evaluation Results:

After 24 hours, the patient's respiratory rate has improved (18 breaths/minute), and oxygen saturation is consistently above 96%

Revision of Care Plan

No immediate revision is needed. Continue monitoring and adjust interventions as necessary based on ongoing assessments.