

Mini decreased hgb
9.2, decreased
hematocrit 29.7,



**ASSIGN
BUSTER**

Mini Nursing Care Plan Name: Joy

Pt. Initials: T.

M.

Date(s) of Care: 1/17/18 Actual Nursing Diagnosis

(What is the main problem?): Noat risk nursing diagnosis Excess Fluid

Volume Related To compromised regulatory mechanisms as evidenced by dyspnea when laying flat, abnormal breath sound (crackles), pitting edema +3 on feet, edema, BP changes, weight gain, anuria, decreased hemoglobin and hematocrit lab values, low WBC.

Also, patient history of renal insufficiency. Pathophysiology: During fluid volume excess, hydrostatic pressure is higher than the usual pushing excess fluids into the interstitial spaces. Since fluids are not reabsorbed at the venous end, Fluid volume overloads the lymph system and stays in the interstitial spaces leading the patient to have edema, weight gain, pulmonary congestion and HPN. (Taylor, 2015) Due to renal insufficiency, based on patient history of renal disease, decrease ability of the kidney to concentrate urine and impaired excretion of fluid thus leading to anuria.

As Evidenced By (objective/subjective assessment data): – Weight gain, complaint of swelling in legs and feet, inability to lay flat and having difficulty in breathing, peripheral edema pitting edema +3, BP changes, decreased Hgb 9. 2, decreased Hematocrit 29.

7, anuria, increased BUN 21, WBC 4. 100 per microliter, and Creatinine 3. 06, dyspnea, on right upper lobe of the lung pulmonary edema according to the chest XR (01/13/18, crackles heard during physical assessment on RUL of the lung Achievable Objective (What do we want the patient to achieve?) The patient will demonstrate...(measureable and specific) Short Term: (I wrote only short term since we suppose to write realistic and interventions that we

participated) 1. Patient's vital signs will be within normal limits by the end of shift 2. Patient's BUN, Cr, sodium, and potassium levels will stay within acceptable range and I and O will not exceed limits by the end of shift 3.

Reduce patient discomfort with breathing and help chest expansion by the end shift 4. Patient will tolerate restricted fluid and restricted diet intake and restricted diet by the end of the shift 5. Decrease peripheral edema to +1 or 0 by the end of the shift. 6. Walk patient at least two times or exercise in a bed by the end shift.

SUBJECTIVE DATA (all data that supports nursing dx and interventions)

(Remember: What the patient says) – “ I gain weight and my feet swelling. I feel shortness of breath most of the time especially when I am laying down, also I got diagnosed two years ago end stage of renal disease and kidneys do not produce urine (last urination seven days ago) that's why I am getting hemodialysis” (last dialysis on 1/17/18) – anxiety – pt renal diet (low potassium, sodium, and low phosphorus) OBJECTIVE DATA Note: all data that supports the nursing dx and interventions. You must cluster this data from physical assessment, the EHR, MAR, and other sources (Remember: What you observe and assess) – Weight gain; six pound in three days – pitting edema on both feet +3 – BP was taken in the morning was 118/62 (night shift values and yesterday's values difference is noted) – lab 1/17/18 Hgb 9.

2, Creatinine 3. 06, Hct 29. 7, BUN 21, low RBC 3. 00 Note: electrolytes and PH within normal range (sodium 143, potassium 4.

4, phosphorus 2.8, WBC 4, 100 per microliter) – complain of dyspnea when lying flat – CXR; right upper lobe lung pulmonary edema – crackles heard during physical assessment on RUL – hemodialysis three times in a week

Interventions: Must include assessment (monitoring), action (what you do), and patient teaching. Add any multidisciplinary referral as appropriate.

(What will you do to help pt achieve goal?) Scientific Rationale for each nursing intervention. Why are you doing these interventions? (must cite source)

1. Monitor VS and breath sounds at least every 4 hours; record and report changes

1. Any change parameters may be sign of altered electrolyte or fluid status (Taylor, 2015, p. 122).

2. Position patient such as Fowler or Semi –Fowler’s to aid breathing instead of lying flat

2. This positioning increase chest expansion and improve ventilation (Taylor, 2015, p. 121).

Monitor I and O, BUN, RBC, creatinine, Hb, Hct levels, daily weight

3. Creatinine and BUN indicate kidney function, H/H indicate blood volume in relation to RBC, and daily weights indicate fluid volume in the body (Ackley, 2016, p. 394).

4. Explain reasons for fluid and dietary restrictions (low potassium, low phosphorus, and sodium) to help patient understand and follow the treatment plan

4. Better patient understanding enhance patient compliance (Taylor, 2015, p. 122).

5. Provide ordered care for edematous extremities such as elevation, compressions, and muscle exercises

5. Treatments for patient with peripheral edema; exercises that effect the

extremity muscles, use of sequential compression devices, elevation (Cooper, 2011).

6. Increase patient's activity level, as tolerated; ambulate or out of bed.

6. Gradually increasing activity helps body adjust to increased tissue oxygen and possible help with fluid retention in the lungs (Ackley, p. 141).

Evaluation of Objective (check one): MET NOT MET

PARTIALLY MET Explanation of why designated objective was met, not met, or partially met: What was patient's response to the nursing intervention?

Short Term: 1. Patient's VS's stabilized by physician prescribed HTN medication and only 2 episode unstable vs is noted during shift. Goal is MET.

Therefore, a care plan need to be updated 2. Patient's BUN, Cr, sodium, and potassium levels stayed still the same but did not change negatively. Goal partially met. Continue monitor findings, monitor I and O and notify physician or MD. 3. Patient do not complain no more of dyspnea due to Reduce patient discomfort with chest expansion by the end shift.

Met. Therefore, a care plan need to be updated 4. Patient demonstrated better understanding of restricted fluid and diet and followed properly till the end of the shift.

Met. Therefore, a care plan need to be updated 5. Patient's lower extremities edema went down from +3 to +1. Partially met. Therefore, notify a doctor and ask if patient need to be on diuretics.

6. Patient tolerated and walked 2 times by the end of the shift. Met. Still encourage patient more and record any changes. Therefore, we will:

Since patient outcomes were partially met the time frame within the short-term goal must be changed for 24hr period. In addition, patient indicated understanding and demonstration of behavior/lifestyle changes while in the hospital.

Although this shows progress further evaluation should be conducted after the patient is discharged from the hospital. Interventions continued or ongoing nursing plan of care: – Continue to monitor I and O, BUN, RBC, creatinine, Hb, Hct levels, daily weight, record hemodialysis visits and findings – Administer diuretics per doctor's order. – Encourage and teach patient more about activity and exercise