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Acute kidney injury Comfort & daily function

Adult Health Nursing | Comfort & daily function

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

60-year-old woman with reduced urine after acute illness. Care stage: During supported recovery and essential daily activity.

Medical history: Urine output fell during the current acute illness. Earlier renal history and all recent medicines need review; acute changes are documented against the available baseline. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Nausea, fatigue and much less urine than usual.

Objective findings and required checks: Urine output has fallen and renal markers are rising; volume status needs careful assessment.

Physical examination and investigations: Trend renal function, electrolytes, urine output, medicines and investigations for the cause, including obstruction when suspected.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Acute kidney injury: Acute loss of kidney function disrupts fluid, electrolyte and waste regulation.

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Medical / surgical management

Escalate low output, assess fluid status and implement cause-specific treatment with renal-dose review.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Medication review	Identify nephrotoxic or renally cleared medicines	Prescriber or pharmacist adjusts the regimen
prescribed fluid or other therapy	Treat the assessed cause	Monitor for both underfilling and overload.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Nausea, fatigue and much less urine than usual. Urine output has fallen and renal markers are rising; volume status needs careful assessment. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize urinary elimination affected by illness or obstruction; fluid accumulation affecting comfort or function; possible treatment-related harm requiring prompt assessment; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

During the next agreed care or activity session: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Escalate low output, assess fluid status and implement cause-specific treatment with renal-dose review. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This

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vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about dysuria, urgency, retention and usual urinary pattern. Assess: Assess output, discomfort, bladder findings and relevant urine tests.	Urinary elimination affected by illness or obstruction. Possible factors: altered bladder function, irritation or drainage difficulty. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Urine drainage and comfort improve within the agreed review interval. Longer-term: Before the clinically approved transition or agreed follow-up: Explains hygiene, catheter instructions if applicable and follow-up needs.	1. Measure urine trends and assess pain, retention or blocked drainage promptly. Rationale: Obstruction and low output may require urgent intervention. 2. Support privacy and indicated hygiene while avoiding unnecessary catheterization. Rationale: Comfort and infection prevention support recovery. 3. Collect ordered samples correctly and implement prescribed treatment. Rationale: Reliable assessment guides targeted management. 4. Escalate low output, assess fluid status and implement cause-specific treatment with renal-dose review. Rationale: Acute loss of kidney function disrupts fluid, electrolyte and waste regulation. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about breathlessness, swelling and recent weight gain. Assess: Monitor edema, respiratory findings, weight, intake/output and electrolytes.	Fluid accumulation affecting comfort or function. Possible factors: impaired fluid handling or excess retention. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: No progression of respiratory distress or edema occurs during the observation period. Longer-term: Before the clinically approved transition or agreed follow-up: Explains prescribed fluid, salt, weight-monitoring and follow-up instructions.	1. Use consistent weighing and intake/output records. Rationale: Comparable measurements help identify fluid trends. 2. Assess respiratory changes and elevate the head of the bed if tolerated. Rationale: Pulmonary fluid accumulation may compromise breathing. 3. Implement only prescribed fluid limits and diuretic treatment; monitor renal function and electrolytes. Rationale: Treatment must balance fluid removal with circulation and electrolyte safety.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about medicine names, timing, symptoms and non-prescribed products. Assess: Review observations, medication record and relevant drug-specific investigations.	Possible treatment-related harm requiring prompt assessment. Possible factors: adverse medication effects or an administration problem. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: The suspected adverse event is escalated and no further avoidable exposure occurs. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the revised medication plan and warning symptoms before discharge.	1. Assess airway, breathing, circulation and the time course of symptoms. Rationale: Serious adverse reactions require immediate stabilization. 2. Escalate suspected toxicity and follow the authorized hold, monitoring or antidote instructions. Rationale: Treatment decisions depend on the drug and clinical severity. 3. Document and communicate the reaction and reconcile the medicine list. Rationale: Accurate records reduce repeat exposure and support pharmacovigilance.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: During the next agreed care or activity session: Explains the most	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain fluid instructions, avoidance of unapproved nephrotoxic products and repeat renal testing. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain fluid instructions, avoidance of unapproved nephrotoxic products and repeat renal testing.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Hyperkalemia-related signs, pulmonary edema, severe acidosis or worsening consciousness needs urgent review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Acute loss of kidney function disrupts fluid, electrolyte and waste regulation.

- Priority concerns: Urinary elimination affected by illness or obstruction; Fluid accumulation affecting comfort or function; Possible treatment-related harm requiring prompt assessment; Learning needs about the condition and care plan.

- Hyperkalemia-related signs, pulmonary edema, severe acidosis or worsening consciousness needs urgent review.

- Explain fluid instructions, avoidance of unapproved nephrotoxic products and repeat renal testing.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

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