Nurses Content
Downloaded from nursescontent.com

Chronic kidney disease Initial assessment

Adult Health Nursing | Initial assessment

For educational purposes only.

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

55-year-old man with established advanced CKD. Care stage: At the first supervised assessment.

Medical history: Advanced chronic kidney disease is already under renal follow-up. Fatigue, poor appetite and edema have increased recently. 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 wants to know which concern needs attention first.

Clinical assessment

Subjective: Fatigue, reduced appetite and ankle swelling.

Objective findings and required checks: Edema and reduced exercise tolerance; electrolyte and anemia monitoring are needed.

Physical examination and investigations: Review estimated filtration, electrolytes, hemoglobin, urine albumin and individualized renal follow-up.

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

Clinical focus and pathophysiology

Chronic kidney disease: Long-term nephron loss impairs filtration and endocrine functions.

Nurses Content For educational purposes only. 1 / 7

Nurses Content
Downloaded from nursescontent.com

Medical / surgical management

Follow the renal plan for medicines, diet, fluids, anemia care and dialysis preparation when relevant.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed renal medicines	Manage identified CKD complications	Monitor drug-specific parameters and interactions
phosphate binder when prescribed	Control phosphate with meals	Check timing and relevant laboratory results.

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

Nursing process - ADPIE

Assessment

Fatigue, reduced appetite and ankle swelling. Edema and reduced exercise tolerance; electrolyte and anemia monitoring are needed. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize fluid accumulation affecting comfort or function; nutritional intake below current needs; movement limited by weakness, discomfort or restriction; 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

After the first indicated intervention, at the documented review time: 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

Follow the renal plan for medicines, diet, fluids, anemia care and dialysis preparation when relevant. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. 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 vignette provides no completed patient outcome.

Nurses Content For educational purposes only. 2 / 7

Nurses Content
Downloaded from nursescontent.com

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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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 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: After the first indicated intervention, at the documented review time: 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. 4. Follow the renal plan for medicines, diet, fluids, anemia care and dialysis preparation when relevant. Rationale: Long-term nephron loss impairs filtration and endocrine functions. 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.

Nurses Content For educational purposes only. 3 / 7

Nurses Content
Downloaded from nursescontent.com

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about usual diet, recent intake, weight change and food access. Assess: Assess growth or weight trends, intake record and relevant nutritional findings.	Nutritional intake below current needs. Possible factors: poor appetite, increased requirements or feeding difficulty. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Tolerates the agreed nutrition plan without new complications. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the individualized meal or feeding plan and follow-up arrangements.	1. Assess nutritional risk and confirm swallowing safety and any fasting order. Rationale: The appropriate feeding route depends on clinical safety. 2. Offer suitable small meals or prescribed feeds with dietitian input when indicated. Rationale: Individualized support improves intake and nutrient adequacy. 3. Monitor tolerance, weight or growth and metabolic findings where required. Rationale: Progress and complications guide adjustment of support.	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 usual mobility, fatigue and help needed with activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Movement limited by weakness, discomfort or restriction. Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Completes a jointly agreed movement task safely with appropriate assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the home exercise or mobility plan before discharge.	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching support to ability prevents injury. 2. Plan graded movement, position changes and rest with physiotherapy where indicated. Rationale: Progressive activity supports function while limiting exhaustion. 3. Monitor tolerance and stop for new concerning symptoms. Rationale: Symptoms may indicate unsafe exertion or deterioration.	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: After the first indicated intervention, at the documented review time:	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

Nurses Content For educational purposes only. 4 / 7

Nurses Content
Downloaded from nursescontent.com

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.	Explains the most 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. Teach the individualized diet and fluid plan, medicine safety, access care if relevant and follow-up. 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.

Nurses Content For educational purposes only. 5 / 7

Nurses Content
Downloaded from nursescontent.com

Health education and continuing care

Teach the individualized diet and fluid plan, medicine safety, access care if relevant and follow-up.

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

New severe breathlessness, chest pain, marked weakness or altered consciousness requires urgent assessment.

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

- Long-term nephron loss impairs filtration and endocrine functions.

- Priority concerns: Fluid accumulation affecting comfort or function; Nutritional intake below current needs; Movement limited by weakness, discomfort or restriction; Learning needs about the condition and care plan.

- New severe breathlessness, chest pain, marked weakness or altered consciousness requires urgent assessment.

- Teach the individualized diet and fluid plan, medicine safety, access care if relevant and follow-up.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Health Alterations - Open RN / WisTech Open, 2025
https://wtcs.pressbooks.pub/healthalts/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

Original cases and care-plan wording by Nurses Content. Linked sources support further study; source terms and local clinical requirements apply. Prepared 23 November 2026. Not independently clinically peer reviewed.

Nurses Content For educational purposes only. 6 / 7

Nurses Content
Downloaded from nursescontent.com

Rights and reuse

Delivered by Nurses Content. Copyright claims apply only to original material owned by its authors. Medical facts, statutory exceptions and third-party/open licence rights remain unaffected. See the website's /policies/reuse/ page for terms.

Nurses Content For educational purposes only. 7 / 7