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Fluid accumulation affecting comfort or function Chronic kidney disease

Adult Health Nursing | Focused diagnosis-based template

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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.

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.

Medical / surgical management

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

Illustrative drug and treatment study

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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.

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Focused nursing-problem template

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: At the next patient-specific reassessment: 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.

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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

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/

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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

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