Patients info label here

Renal Failure

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Impaired urinary elimination *Related factors:* Multiple causality Servere renal ischemia secondary to sepsis,shock,hypovol. Nephrotoxic drugs Renal vascular occlusion Hemolytic blood transfusion reaction *Symptoms / Risk factors:* Increased blood urea nitrogen(BUN) and serum creatinine Hematuria,proteinuria Dysuria Frequency of voiding Nocturia Reduced creatinine clearance Urine output less than 400 ml/ 24 hours Weight gain *Outcome / Goal:* BUN and electrolytes within or near normal levels Urine output greater than 30ml /hr Urine output greater than_____		**Urinary Elimination Management** Monitor intake and output and record. Report output less than 30 ml/hour Monitor urine specific gravity Monitor lab results: Sodium,Potassium,Calcium,phosphate ,Magnesium and PH Monitor urinlysis: urine,electrolytes,creatinine clearance ,BUN and creatinine Administer fluids /diuretics as precribed Monitor vital signs _____ Palpate bladder for distention Waight daily Monitor for signs and symptoms of excess fluid volume: Edema and Hypertens	
	Excess fluid volume *Related factors:* Excess fluid intake Renal insufficiency or failure Excess sodium intake *Symptoms / Risk factors:* Edema, may progress to anascara Weight gain over short period of time Hypertension Jugular vein distention Tachycardia *Outcome / Goal:* Achieving fluid and electrolyte balance		**Fluid Monitoring** Monitor for signs and symptoms of hypovolemia or hypervolemia Administer IV medications in least amount of fluid as possible Administer oral and IV fluids as prescribed Monitor urinary output and urine specific gravity Monitor intake and output including urine Obs fluid balance _____ hour Monitor serum and urine electrolyte concentrations Obs vital signs Bp. O2 and pulse Obs. orthostatic blodpressure Watch for cardiac arrhythmia and heart failure from hyperkalemia Instruct patient about the importance of following prescribed diet Monitor acid base balance	
	Risk for decreased cardiac output *Related factors:* Dysrhytmias Hyperkalemia Hyponatremia Hypocalcemia Volume overload leading to heartfailure *Symptoms / Risk factors:* Shock Cardiac arrest Abnormal vital signs *Outcome / Goal:* Normal cardiac output Normal vital signs		**Hemodynamic Regulation** Obs cardiac dysrhythmias, treat as appropriate If signs of decreased CO: administer medication and/or IV fluids as prescribed Consider administering: sodium bicarbonate and calcuim salts Obs urine output (catheter) Monitor serum electrolytes: k+, Nacl Obs nausa and vomiting Obs lethargy and weakness Obs increased respiratory rate,depth and dyspnea Obs fatigue and malaise Obs decreased level of consciousness	
	Risk for injury *Related factors:* Abnormal blood profile *Symptoms / Risk factors:* Anemia Tissue hypoxia *Outcome / Goal:* Display homeostasis		**Bleeding Precautions** Hematest body fluids—urine, stool, and vomitus—for occult blood Monitor vital signs and detect any signs of bleeding Monitor BUN Administer O2 as prescribed Administer blood products, as indicated	

(Plan continues on the next page

Patients info label here

Renal Failure

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Imbalanced nutrition: Insufficient *Related factors:* Diarrhea Nausa ,vomiting Difficulty swallowing and dysphagia Decreased appetit *Symptoms / Risk factors:* Documented inadequate caloric intake Dehydration Loss of weight with adequate food intake *Outcome / Goal:* Nutritional status to almost normal		**Nutrition Management** Assess overall nutritional status and history Consult a dietitian Allow adequate time for meals, avoid rushing the patient Antifungal or anesthetic mouthwash, if indicated Adjust patassium restriction as indicated Assess abdomen ,bowel sounds, abdominal distention and nausa Administer enteral or parenteral feedings, as indicated Monitor weight ____ weekly, Encourage patient/family to keep weight /diet log	
	Ineffective tissue perfusion:Renal *Related factors:* Renal failure acute Renal failure chronic *Symptoms / Risk factors:* Abnormal serum electrolyte levels Dark, concentrated urine Decreased urine output Increased blood pressure Pheripheral edema *Outcome / Goal:* Patient maintains fluid balance Patient maintains urine specific gravity with normal limits Blood pressure normal Patient's weight doesn't fluctuate		**Fluid Monitoring** Monitor intake and output including urine Monitor urinary output and urine specific gravity Obs fluid balance _____ hour Obs vital signs Bp. O2 and pulse Obs. patients weight_____weekly **Fluid Management** Refer patient to dietitian Encourage fluid intake by offering fluids regularly Provide fresh water and oral fluids preferred by the client Allow frequent rest periods Explain reasons for thearpy and it inteded effects to patient and family members	
	Risk for infection *Related factors:* Inadequate primary defenses: Renal failure Indwelling catheter *Symptoms / Risk factors:* Chronic disease Temp > 37.5 Stasis of body fluids Decreased hemoglobin and leukopenia Broken skin *Outcome / Goal:* Risk for infection reduced through treatment States symptoms of infection of which to be aware Maintains white blood cell count Demonstrates appropriate hygienic measures		**Infection Protection** Observe and report signs of infection such as redness and increased tempera Assess temperature of neutropenic clients every _____ hours Obs laboratory values (e.g., white blood cell count, protein and albumin) Assess skin for color, moisture, texture, and turgor Use proper hand washing techniques before and after giving care to client Provide well site care for all peripheral, central venous and arterial catheters Encourage a balanced diet Encourage adequate rest to bolster the immune system Keep the client in a private room, if possible Follow precautions for airborne-, droplet-, and contact-transmission	
	Impaired skin integrity *Related factors:* Altered circulation Altered fluid status Altered nutritional state (e.g., obesity, emaciation) *Symptoms / Risk factors:* Destruction of skin layers (dermis) Disruption of skin surface (epidermis)		**Skin Surveillance** Inspect patient's skin every shift, document skin condition and report change Apply skin moisturizers to maintain suppleness and prevent cracking and fissures Avoid applying drying agents to skin Encourage ambulation Kepp patient's linens dry, clean and free from wrinkles or curmps Monitor patient's nutitional status every _____ hours and document	

(Plan continues on the next page

Patients info label here

Renal Failure

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Deficient knowledge *Related factors:* Unfamiliarity with disease and treatment Cognitive limitation *Symptoms / Risk factors:* Inaccurate follow through of instruction Increase in anxiety level Multiple questions *Outcome / Goal:* Identify and use available resources appropriately Patient verbalize understanding of disease and procedure		Teaching: Disease Process Assess knowledge of the disease and treatment Acknowledge patient's knowledge about condition Discuss symptoms and interventions Discuss effects of anemias on preexisting conditions Discuss therapy/treatment options Emphasize need for long-term follow up and periodic reevaluation. Identify appropriate community resources Patient education:Disease process,Diet,Medication effects and Exercise Outline normally expected limitations, if any, on ADLs	

Plan created:12.11.2016 by:_____

signature