

Risk for imbalanced fluid volume

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	<p>Risk for imbalanced fluid volume</p> <p>Related factors:</p> <ul style="list-style-type: none"> Fluid loss or bleeding Hypermetabolic state, fever Increased peritoneal permeability Renal insufficiency Vomiting <p>Symptoms / Risk factors:</p> <ul style="list-style-type: none"> Acute weight gain decreased skin/tongue turgor Elevated BP Fluid intake low low bloodpressure Peripheral edema Weakness tachycardia <p>Outcome / Goal:</p> <ul style="list-style-type: none"> Maintain adequate fluid balance while hospitalized Maintain normal blood pressure, pulse, and body temperature Maintain urine output more than 1300 mL/day No bleeding and /or fluid loss No edema Normal weight Normal vital signs Patient's fluid volume excess is reduced 		<p>Fluid Management</p> <ul style="list-style-type: none"> Assess skin turgor, mucous membranes, and thirst Assess for distended neck and peripheral vessels Advise to avoid fatty foods Allow frequent rest periods Change position frequently. Elevate feet when sitting Discuss strategies to stop vomiting and laxative/diuretic use. Encourage fluid intake by offering fluids regularly Advance diet from clear liquids to low-residue diet when allowed Encourage increased oral intake based on individual needs Encourage patient (if prescribed) to take in po fluid Estimate wound drainage and insensible losses Explain reasons for therapy and it intended effects to parents and family member Explain reasons for therapy and it intended effects to patient and family member Give anti-emetic drugs as prescribed Maintain chair rest or bedrest in semi-Fowler's position Maintain intravenous infusion as prescribed Measure intake and output; weigh _____ Measure urine specific gravity after each voiding _____ Minimize insensible fluid losses through use of clothing Monitor and record patient's intake (IV) and output (urin) Monitor client's vital signs and signs of possible hemorrhage and perforation Monitor Lab tests such as electrolytes Monitor vital sign (BP and pulse) Monitor vital signs and central venous pressure Provide prescribed diet – liquid or soft diet during acute phase. Restrict oral intake until vomiting stops Refer patient to dietitian <p>Fluid Monitoring</p> <ul style="list-style-type: none"> Monitor for signs and symptoms of hypovolemia or hypervolemia Monitor acid base balance Monitor intake and output including urine Monitor serum and urine electrolyte concentrations Obs vital signs Bp. O2 and pulse Obs. orthostatic bloodpressure <p>Peritoneal Dialysis Therapy</p> <ul style="list-style-type: none"> Assess for headache, muscle cramps, mental confusion, and disorientation. Assess patency of catheter, noting difficulty in draining Change position frequently. Head of bed 45 deg. Turn side of side Check tubing for kinks; note placement of bags. Elevate edematous extremities Have client empty bladder before peritoneal catheter insertion Instruct fluid restrictions as appropriate Measure inflow and outflow (outflow should be greater than or equal to inflow) Monitor abdominal distention associated with decreased bowel sounds. Monitor breathing sounds and change in effort of breathing Monitor lab results (sodium) Monitor report of pain and or bleeding from catheter insertion area Monitor vital sign (BP and pulse) Note presence of fecal material in dialysate effluent Note reports of dizziness, nausea, and increasing thirst. Note reports of intense urge to void or large urine (when start of dialysis) Obtain baseline weight when peritoneal cavity is empty, then every day 	