N311 Care Plan #2

Lakeview College of Nursing

Anita Wilson

Demographics

Date of Admission	**Patient Initials**	**Age**	**Gender**
10/21//2020	B.S.	07/04/1941 (79 years old)	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Black or African American	Retried	Widowed	No Known Allergies
Code Status	**Height**	**Weight**	**Assistive Device**
DNR DNI	4'11"	163 pounds (74.2 kg) BMI: 33.0	Walker, glasses
Primary Language	**Religion**		
English	Christian		

Medical History

Past Medical History:

Patient has a medical history of the following: carcinoma (HCC), congestive heart failure, coronary artery disease, diabetes mellitus, dialysis patient, heart murmur, hypertension, hypothyroidism, kidney disease, multiple myeloma

Patient denies any childhood illness or infection. Patient was hospitalized prior twice due to surgery and hypertension. Patient denies any past screenings or examinations with the exception of her mammogram which was last completed in February of 2020.

Past Surgical History:

1. Central venous catheter (R; 2/2/19)
   -Procedure: insertion of temporary dialysis catheter
2. Insertion Dialysis Catheter (CL; 2/7/2019)
   -Procedure: insertion of dialysis catheter
3. Hysterectomy (patient unsure exactly what year this procedure occurred)

Patient denies any other past surgeries (besides the one listed above) or upcoming surgeries. Patient denies any c-section. Patient has had surgery to remove all her teeth in 2012 and now has full dentures.

Family History:

Mom (decreased)- history of hypertension
Dad (deceased)- no known diseases

Social History (tobacco/alcohol/drugs):
Patient reports she never smoked or used smokeless tobacco. Patient denies any use of recreational or illicit drug and alcohol use. For living arrangements, patient lives with her oldest son in a townhome in Illinois.

Admission Assessment

Chief Complaint:
Hypertensive urgency and headache

History of present Illness:

B.S. is a 79 year old female with past medical history of diabetes, coronary artery disease, hypertension, multiple myeloma, hypothyroidism, end-stage renal disease on hemodialysis who was sent to the emergency room department from dialysis center due to elevated blood pressure and headaches. Patient has known history of hypertension and she admits compliance with her medication. Patient states that she went to dialysis center for her regular dialysis and her blood pressure was elevated with systole reading of over 200. The highest blood pressure reading level was 210 systolic. She did not get her scheduled dialysis today and was sent to the emergency room for hypertensive urgency management. In the emergency room, she receive 20 mg of iv labteal and subsequently admitted for further management. During this encounter, patient denied any current symptoms. Her headache resolved. She denied any chest pain, shortness of breath, abdominal pain and blurred vision. Patient stated she pain began earlier in the day, but progressed as the day went on. Patient pointed to the pain starting in her temporal part of her head. Patient stated the pain progressed, but decreased after the medication they administered to her in the emergency room. Patient stated the pain was a sharp and intense pain that did not radiate to any other locations in her body. Patient stated the bright lights in the emergency room intensified the pain, but once she got

the medication, her pain decreased drastically. Patient is currently working with the health care team to continue get her hypertension under control.

Primary Diagnosis

Primary Diagnosis on Admission: end stage rental disease on hemodialysis
Secondary Diagnosis: no intractable headache, unspecified chronicity pattern, unspecified headache type

Pathophysiology of the Disease, APA format: (Chronic Renal Failure)

Chronic renal failure is irreversible and progressive. This disease has a gradually onset that may develop over a span of a few months. The incidence of individuals being diagnosed with CRF has increased in the United States. It is said that, “this increase is partially explained by the increase in the prevalence of diabetes and hypertension the most two common causes of CKD” (Capriotti, 2020). There is states to be five stages of chronic renal failure. The first stage is kidney damage with normal or increased GFR that is greater than 90 milliliters per minute. Stage two is a mild reduction if GFR at about 60 to 80 milliliters per minute. Stage three is moderate reduction in GFR at about 30 to 59 milliliters per minute. The fourth stage, is severe reduction in GFR at about 15 to 39 milliliters per minute. Lastly, the fifth stage is fetal and is when the kidney is in complete failure with a GFR lower than 15 milliliters per minute (Capriotti, 2020). With this patient is has stage five renal failure. In stage five, “renal failure develops and GFR falls less than 5% of normal” (Narres et al., 2016). At this particular stage, nephrons cannot accomplish complete filtration of the bloodstream. The kidney’s varied functions, such as erythropoietin synthesis, blood pressure patience, and acid-base are lost (Capriotti, 2020). Fluid, electrolyte and acid-base imbalances occur and effect different organ systems. ESRD occurs with widespread effects of urine in the bloodstream. The kidneys waste away and decrease in function and begin smaller. Dialysis and renal transplant are the only

options for survival in most cases. Clinical symptoms that can present in ESRD are confusion, disorientation and stupor due to the brain's inability to function in a high nitrogenous environment (Capriotti, 2020). Hyperkalemia can also occur due to the fluid imbalance and this can be very fetal for patients to have. Hyperkalemia can also cause muscle weakness over a period of time. Severe fatigue, weakness and difficulty breathing can also occur hyper to increased blood loss which can also result in bruising and spontaneous bleeding. End stage renal disease is diagnosis with a "CBC with differential, serum electrolytes, serum creatine, total albumin, BUN and urinalysis" (Capriotti, 2020). If abnormal, all of these labs will show renal failure. Noninvasive renal imaging studies such as x-rays, ultrasounds and CT scans can also be done. Treatment for this disease includes blood pressure management, calcium supplements that contain vitamin D, dialysis or a kidney transplant. Complications that could arise would be a body wide infection as the disease progresses and the patient develops issues related to fluid overload and hypertension. Without proper and immediate interventions and treatment, death could quickly occur with these patients.

Pathophysiology References (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives 2nd Edition* (2nd ed., p. 562). Philadelphia: F A Davis.

Narres, M., Claessen, H., Droste, S., Kvitkina, T., Koch, M., Kuss, O., & Icks, A. (2016). The Incidence of End-Stage Renal Disease in the Diabetic (Compared to the Non-Diabetic) Population: A Systematic Review. *PLOS ONE, 11*(1), e0147329. https://doi.org/10.1371/journal.pone.0147329

Laboratory Data

COMPLETE BLOOD COUNT

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RED BLOOD CELLS (carry oxygen)	F: 4.2-5.5	**3.13**	**2.82**	This patient has ESRD, so the kidneys are not working as well as they should so the kidneys cannot make enough erythropoietin. Without enough erythropoietin, the body cannot make enough red blood cells.
HEMOGLOBIN (oxygen-carrying protein in RBCs)	F: 12-16	**10.7**	**9.4**	Most patients on dialysis have low hemoglobin levels and anemia because the kidneys are not making enough erythropoietin to help the body make enough red blood cells. You also lose some blood during hemodialysis treatments and frequent blood test.
HEMATOCRIT (the proportion of RBCs to the fluid component, plasma in your blood)	F: 36-46	37	38	
PLATELETS (help with blood clotting)	150,000-400,000	**101,000**	**112,000**	This is due to some bleeding that may have occurred during dialysis.
WHITE BLOOD CELLS (fight infection)	4,000-10,000	**2.70**	**2.10**	Chronic kidney disease can cause a decrease in WBC, because of infections and malnutrition like vitamin deficiencies. It can also be due to the chronic infection and inflammation in the kidneys.
NEUTROPHILS (type of WBC that the bone marrow creates; travel into blood stream and move to areas of infection and neutralize that area)	40-60	53.4	44.5	
LYMPHOCYTES (B cells: produce antibodies to attack bacteria T-cells: kill infected cells	20-40	29.2	36.0	

MONOCYTES (fight infection; help remove dead tissues; destroy cancer cells)	2-8	**0.40**	**0.30**	The cause of these low values with this patient is due to chronic infection.
EOSINOPHILS (participating in immediate allergic reactions)	1-4	**0.0**	**0.10**	The cause of these low values with this patient is due to chronic infection.
BANDS (immature form of neutrophils; produced in excess during infection to help fight disease)	3-7	N/A	N/A	

Chemistry

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
NA- (Control BP and blood volume; needed for muscle and nerves to work)	135-145	135	135	
K+ (helps your nerves to function and muscles to contract; heartbeat stay regular; move nutrients into cell and waste products out of cell)	3.5-5.0	3.5	3.8	
Cl- (helps keep the amount of fluid inside and outside of your cells in balance; maintain blood volume, BP and pH)	95-105	98	98	

CO2 (regulates the pH of blood, stimulates breathing, and influences the affinity hemoglobin has for oxygen)	23-30	29	29	
Glucose (for energy)	70-110	102	98	
BUN (measures the amount of nitrogen in your blood that comes from the waste product urea; indicates how well your kidney are working)	10-20	**30**	**37**	Healthy kidneys take urea nitrogen out of the blood and remove it in the urine. Since this patient has ESRD (stage 5) and her kidneys are not working well, the urea nitrogen will stay in the blood.
CREATININE (to be filtered and eliminated in urine)	0.6-1.5	**5.01**	**6.01**	When the kidneys are not working well, creatinine builds up in the blood. If the kidney loses their ability to filter blood, this will cause GFR to be decreased which in turn causes more creatinine to accumulate and serum creatinine will rise. This measures how well the kidneys are working.
ALBUMIN (helps keep fluid in your bloodstream so it doesn't leak into other tissues)	3.5-5.0	4.3	4.0	
CALCIUM (stored in bones and teeth; supports structure; carries massages between the brain and body parts)	8.5-10.0	9.7	8.6	
MAGNESIUM (required for energy production)	1.5-2.5	N/A	N/A	
PHOSPHATE (build and repair bones and teeth, help nerves function, and make muscles contract)	2.8-4.5	**5.5**	N/A	Since this patient's kidneys are failing and not working properly, they cannot remove extra phosphorus in the blood very well. Extra phosphate causes the body to pull calcium out of the bones which makes them weaker.
BILIRUBIN (orange-yellow pigment that occurs normally when	0-0.3	**0.8**	**0.7**	Kidney damage is the main reason these labs are elevated. Since this patient has kidney disease that is chronic it is very well over time

part of your red blood cells break down)				it can affect the liver's function.
ALK PHOS (mostly found in the liver, bones, kidneys, and digestive system. When the liver is damaged, ALP may leak into the bloodstream)	20-90	65	68	

Urinalysis

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Reason for Abnormal** *An updated urinalysis was not administered to this patient, besides the one taken upon admission to the ED on 10/19/20.*
COLOR & CLARITY	Colorless-Yellow, Clear	Yellow, **cloudy**	N/A	The cause of cloudy urine could be because of the buildup of certain minerals in the body since the body is no longer properly removing wastes and extra fluid in the body.
pH	6-8.0	**5**	N/A	The renal system affects pH by reabsorbing bicarbonate and excreting fixed acids.
SPECIFIC GRAVITY (test compares the density of urine to the density of water; help determine how well your kidneys are diluting your urine)	1.005-1.030	1.013	N/A	
GLUCOSE	Negative	Negative	N/A	
PROTEIN	0-8	3	N/A	
KETONES (fuels for the body that are made when glucose is in short supply)	Negative	Negative	N/A	
WBC	0-4	0	N/A	
RBC	0-3	0-2	N/A	

LEUKOESTERASE	Negative	N/A	N/A	

Cultures

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
URINE CULTURE	Negative	None ordered	N/A	
BLOOD CULTURE	Negative	Occult blood negative	N/A	
SPUTUM CULTURE	Negative	None ordered	N/A	
STOOL CULTURE	Negative	None ordered	N/A	

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference. St. Louis, MO: Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests:

CT Head or Brain without Contrast (10/21/20) @ 0841

Clinical indications: Hypertension

No intracranial blood, no mass lesion, no mass effect is identified. The ventricles, listen and sulci are appropriate for the age of the patient. few sections through the orbitals and paranasal sinuses. Reveal mineral bilateral maxillary and sphenoid sinusitis changes.

Impression: no acute intracranial process is seen.

XR Chest Single View Portable (10/21/2020) @ 0844

Clinical indications: Headache

The lungs reveal no acute infiltrates or signs of pulmonary edema. The hila and the costophrenic angels are unremarkable.

Impression: Portable chest exam showing no acute process.

EKGM on admission (10/21/2020)

Atrial rate- 87
QRS duration- 76
QTC duration- 454
QT duration- 378
Ventricular rate- 87

EKG 12 Lead

Shows a normal sinus rhythm of a rate of 87 beats per minute. Nonspecific ST T wave changes.

No STEMI.

Current Medications

Brand/Generic	**Amlodipine (Norvasc)**	**Carvedilol (Coreg)**	**Gabapentin (Neurontin)**	**Levothyroxine (Synthroid)**	**Sevelamer Carbonate (Renvela)**
Dose	10 mg tablet	6.25 mg tablet	100 mg capsule	100 mcg tablet	1 800 mg tablet (do not crush)
Frequency	Daily	2 times daily	3 times daily	Daily (every morning before breakfast)	3 times daily with meals
Route	Oral	Oral	Oral	Oral	Oral
Classification	Calcium channel blockers	Alpha and beta blocker	Anticonvulsants	Thyroid Hormones	Phosphate binders
Mechanism of Action	Relaxes the blood vessels so the heart does not have to pump as hard	Relaxes smooth muscle in vasculature, leading to reduced peripheral vascular resistance and an overall reduction in blood pressure	Blocks the tonic phase of nociception induced by formation and carrageenan, and exerts a potent inhibitory effect in neuropathic pain models	50% of thyroxine (T4) then gets converted to its active metabolite; the thyroid hormones then work by binding to thyroid receptor proteins contained with the cell nucleus	Prevents hypophosphatemia by binding to dietary phosphate in the gut, preventing its absorption and thus decreasing serum parathyroid hormone levels.
Reason Client Taking	Lower blood pressure	Lowers blood pressure	Neuropathic pain related to ESRD	History of hypothyroidism	Lower blood phosphorus levels since she is on dialysis due to kidney disease
Contraindications (2)	Hypersensitivity to dihydropyridines, amlodipine, severe hypotension, shock, CAD	Severe hypotension, bradycardia that is serve, heart failure requiring inotropic support	Suicidal thoughts, myasthenia gravis, COPD, depression, decreased lung function	Untreated subclinical or overt thyrotoxicosis or MI	

Side Effects/Adverse Reactions (2)	Fatigue, dizziness, nausea, bradycardia	Dizziness, tiredness, diarrhea, lightheadedness	Drowsiness, tremor, decreased LOC, blurred/ doubled vision	Headache, nervousness, muscle weakness, skin rash, hair loss	

Medications Reference (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert

http://www.ismp.org/. Jones & Bartlett Learning. (2019). 2019 Nurse's Drug

Handbook. Burlington, MA

Assessment: *Physical Exam*

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is an elderly African American female. She is alert and orientated to situation and person, time and place. Patient wears glasses and has good hearing. Patient appears to be well groomed and in no acute distress, well-developed and not ill-appeared. Patient calm and cooperative. **Patient denies fatigue, weight changes, fevers, chills, night sweats.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is warm, pink and dry. No rashes or lesions or erythema present. Patient has no bruising to her skin. Patient is not pale or ashy. Patient's nails are without clubbing and cyanosis. Skin turgor normal mobility, quick to return to original state. Patient had no wounds or drains at the time of this assessment. Patient has peripheral IV line single lumen median cubital vein (antecubital fossa) right 22 gauge. When asked patient stated her peripheral IV site does not feel painful or tender. Patient also has a dialysis port in her right upper chest area. Dressing is dry and intact. Patient's Braden score is an 19 (4 – no impairment, 3 – occasional moist, 3 – walk occasional, 3 – slight limited, 3 – adequate, 3 – no apparent problem). **Patient denies dryness, rashes, lesions, non-healing sores, hair changes, purities.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head and neck are symmetrical. Trachea is midline without deviations, thyroid is not palpable, no nodules noted at the time of assessment. Bilateral carotid pulses are palpable and strong. No swollen lymph nodes in the head or neck region. Bilateral sclera white, bilateral cornea clear. Bilateral conjunctiva pink, slight visible discharge in left eye. Bilateral lids are pink and dry without lesion. PERRLA bilaterally, red light reflux present bilaterally. EOMs intact bilaterally. Septum is midline. Bilateral frontal sinuses are nontender and to palpation. Bilateral auricles moist and pink without lesions noted. Dentition is good with dentures, oral mucous overall is moist and pink without lesions noted.

	Dental is edentulous. Patient's hair is thin, grey and course hair texture. Oropharynx is clear. No discharge present right and left ear. External right and left ear normal. Normal range of motion and neck supple. **Patient denies experiencing headaches, head injury, blurry vision, double vision, earache, drainage, change in hearing, nasal congestion, nose bleeds, nasal drainage, dry mouth, sore throat, swallowing difficulty.**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	Clear S1 and S2 sounds heard without the presence of murmurs, gallops or rubs. PMI at 5th intercostal space at MCL. All extremities warm, pink and dry. Peripheral pulses are 2+ throughout bilaterally with the dorsal pedis pulse bilaterally being a 0. Edema was also slightly present in the patient's lower extremities. +3 trace edema noted in the patient's left and right foot. Edema also noted and palpated in patient's right arm. +2 trace edema in patient's right arm. No other edema inspected or palpated in all other extremities. Homan's sign is negative bilaterally. Capillary refill less than 3 seconds in fingers and toes bilaterally throughout. No neck vein distention noted in this patient. **Patient denies chest pain, palpitations, diaphoresis, dyspnea, PND, Orthopnea, claudication.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular, even and symmetrical and nonlabored bilaterally. Lung sounds are clear throughout bilaterally. No wheezes, crackles or rhonchi noted. Bilateral equal air entry. **Patient denies wheezing, cough, increase in sputum production. Anterior, lateral, clear and equal bilaterally.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:**	Patient is on a renal diet while being hospitalized. Patient states she follows the same diet regimen at home and her eldest son prepares her food for him and they closely monitor what she eats. Patient states she had a good appetite and no trouble eating. Patient eats well and shows no signs of difficulty eating. Patient uses no assistive devices to aide in eating. Patient does require set up help with each meal. Patient is 4'11". Patient weights 163 pounds. Patient's abdomen is soft, flat, nontender, no masses noted upon palpation or all four quadrants. Bowel sounds are normoactive in all four quadrants. No CVA tenderness noted bilaterally. There's no abdominal

Drains: **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	tenderness or guarding or rebound pain. No signs of distention, incision, scars, drains or wounds, ostomy or nasogastric feeding nudes/ PEG tubes. **Patient denies nausea, vomiting, diarrhea, abdominal pain, heartburn, jaundice, hematochezia, melena. Last episode of nausea and/or vomiting was "a while ago" according to patient. Patient is passing gas. Patient's last bowel movement was 10/21/2020. Patient's bowel movement was described as being soft, small and brown. _____**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient's urine appears to be yellow, clear and absent of foul odor. Patient has a normal stream of urine and consent flow. Patient's genitals appear to be intact, no abnormalities noted. Patient does not have a catheter at the time of this assessment. Patient voids spontaneous without difficulty. Patient voided 50 ml in total during my shift. Patient described urine production as being decreased of her being on dialysis. **Patient denies burning or pain, hematuria, incontinence, flank pain while urinating. Patient is on dialysis.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐ X** **Needs support to stand and walk☐ X**	Patient appeared to be alert LOC. Patient arousal level was she opened her eyes spontaneously. Patient is a one assist with a walker. Patient demonstrated active range of motion bilaterally throughout. Patient fall risk score is a 21 (3 – cardiovascular medication, 2 – mobility deficit/ weakness, 8 – patient unable to rise from sitting position unless assisted, 8 – unsteady gait or weakness). Patient's bed alarm, fall reduction program maintained, non-skid shoes/ slippers, when out of bed, ambulated encouraged and dorsiflexion/ plantar flexion and anticoagulant therapy initiated. Patient maintains good balance with the assistance of a walker. When ambulating the patient to and from the bathroom, she showed no signs of shortness of breath. Patient is a one assistance with a walker. Patient needs cueing and set up assistance. Patient was encouraged to engage in as much a she can independently; all personal objects within reach. Patient's general motor response was normal.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐**	Patients speech was logical, well-paced, spontaneous and clear. Patient's mood and behavior was cooperative, calm and talkative. Patient's memory happened to be forgetful at times. PERRLA bilaterally. Patient's hand grip and ankle strength were strong bilaterally. Patient is alert and

Orientation: **Mental Status:** **Speech:** **Sensory:** **LOC:**	orientated to situation and person, but disorientation to time and place. Patient is full concisions and alert. Patient displays no signs of confusion. CAM score negative. No acute, inattention, altered LOC, disorganized thinking.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient states she copes with different stressor in her life watching entertaining things on television and spending time with her family but mainly her son since she lives with him. Patient's developmental level is appropriate for her age. Patient stated she is a Christian and was raised in a Christian household. Patient states although she does not attend church as often as she used to, she still believes in God and is fully restored in her faith. Patient states her support team consist of her eldest son and her two other children.

Vital Signs

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0743	78 (right radial)	178/82 (right arm)	14 (unlabored)	98.0 F (temporal)	100% (2.5 L of oxygen)

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
0934	4 out of 10	Lower back	Mild pain	"irritating feeling" when trying to get out of bed and stand up	Patient has PRN Tylenol. Patient refused pain medication, stating the pain was not that severe yet. Patient was reminded of her PRN medications if pain persisted.

Intake and Output

Intake (in mL)	Output (in mL)
200 mL (water)	50 mL (yellow, clear urine, free of foul odor) No bowel movement during shift

For breakfast patient ate toast with jelly and eggs. Patient ate 100% of her breakfast.

Nursing Diagnosis

Nursing Diagnosis	Rational	Intervention	Evaluation
1. Excess fluid volume **related to** renal disease with, renal insufficiency **as evidenced by** blood pressure changes, edema, decreased hemoglobin and hematocrit, third heart sounds	Patient was hospitalized with hypertension related to her end stage renal disease. With ESRD, assessing for crackles in the lungs, changes in respiratory pattern, shortness of breath and orthopnea are caused by accumulation of fluid in the lungs.	1. Maintain clear lung sounds, no evidence of dyspnea or orthopnea by 7a-12:45pm on 10/22/20. 2.Explain actions that will prevent excess volume including fluid dietary restrictions by restricting sodium by 7a-12:45p on 10/22/20.	1. Goal met. Patient maintained clear lung sounds and displayed no signs or verbalized feels of dyspnea or orthopnea during shift on 10/22/20 from 7am to 12:45pm. When ambulating the patient to the bathroom and when standing patient up from a lying to standing position, patient expressed no feels of difficulty breathing or feeling dizzy as if there was a sudden drop in her blood pressure due to change in positioning. Patient stated she felt “ok”. When doing my physical assessment on my patient, I auscultated patient’s lungs and breath sounds and patient did not have any wheezes, rhonchi or crackles present bilaterally throughout. 2. Goal met. Patient’s diet while being hospitalized is a renal diet. For breakfast, I observed the patient eat two slices of toast with jelly and eggs. This meal is low in sodium. Patient was successful in following a restricting sodium diet by the end of the shift on 10/2220 from 7am to 12:45pm. Patient was able to verbalize the important of a low sodium lifestyle when it relates to her ESRD. Patient stated it will “help me feel better so I can go home”.
2. Altered renal tissue	Due to the loss of	1. Patient demonstrate	1. Goal is ongoing. Patient left

perfusion **related to** increase in lab results (BUN, creatinine), edema, hypertension **as evidence by** 178/82 reading in the morning, BUN lab value of 30 on admission and currently 37 and creatinine lab valve of 5.01 on admission and currently 6.01.	kidney excretory functions with end stage renal disease, there is impaired excretion of nitrogenous waste products causing increase in BUN and creatinine. Decrease tissue perfusion can increase blood pressure in an effort to compensate.	behavior and lifestyle changes to monitor and look for complications of impaired tissue perfusion by stating changing in position at least every 2 hours if in bed and monitoring O2 by 12:45pm on 10/22/20. 2. Patient will be able to state the importance of monitoring blood pressure daily by 12:45pm on 10/22/20.	the floor to go to dialysis and this goal was unable to fully be met by 12:45pm on 10/22/20. 2. Goal is met. I verbalized to the patient that uncontrolled high blood pressure can cause arteries around the kidneys to narrow and weaken overtime which decreases deliver of blood to the kidney tissue. Patient appeared to understand and verbalized the information back to me by 12:45pm on 10/22/20.

Other References (APA):

Ackley, B. J., Ladwig, G. B., & Makic, M. B. (2017). Nursing diagnosis handbook: An evidence-based guide to planning care (11th ed.). St. Louis, MO: Elsevier

Concept Map

SUBJECTIVE DATA

Patient stated she felt "ok" when ambulating her to the bathroom. Patient denied feelings of dizziness or lightheadedness or difficulty breathing or short of breath. Patient states she follows a renal diet similar to the one given to her in the hospital. Patient stated her eldest son prepares her meals whom she lives with at home. Patient states the both of them closely monitor her sodium and salt intake.

NURSING DIAGNOSIS/OUTCOMES

1. Excess fluid volume **related to** renal disease with, renal insufficiency **as evidenced by** blood pressure changes, edema, decreased hemoglobin and hematocrit, third heart sounds
-Goal met. Patient maintained clear lung sounds and displayed no signs or verbalized feels of dyspnea or orthopnea during shift on 10/22/20 from 7am to 12:45pm.
- Goal met. Patient's diet while being hospitalized is a renal diet. For breakfast, I observed the patient eat two slices of toast with jelly and eggs. This meal is low in sodium. Patient was successful in following a restricting sodium diet by the end of the shift on 10/2220 from 7am to 12:45pm.
2. Altered renal tissue perfusion **related to** increase in lab results (BUN, creatinine), edema, hypertension **as evidence by** 178/82 reading in the morning, BUN lab value of 30 on admission and currently 37 and creatinine lab valve of 5.01 on admission and currently 6.01.
- Goal is ongoing. Patient left the floor to go to dialysis and this goal was unable to fully be met by 12:45pm on 10/22/20.
- Goal is met. I verbalized to the patient that uncontrolled high blood pressure can cause arteries around the kidneys to narrow and weaken overtime which decreases deliver of blood to the kidney tissue. Patient appeared to understand and verbalized the information back to me by 12:45pm on 10/22/20.

OBJECTIVE DATA

When ambulating the patient to the bathroom and when standing patient up from a lying to standing position, patient expressed no feels of difficulty breathing or feeling dizzy as if there was a sudden drop in her blood pressure due to change in positioning. When doing my physical assessment on my patient, I auscultated patient's lungs and breath sounds and patient did not have any wheezes, rhonchi or crackles present bilaterally throughout. For breakfast, I observed the patient eat two slices of toast with jelly and eggs. This meal is low in sodium. Patient was successful in following a restricting sodium diet.

Patient Information

B.S. is a 79 year old female with a medical history of end-stage renal disease on hemodialysis who was sent to the emergency room department from dialysis center due to elevated blood pressure and headaches. Patient has known history of hypertension and she admits compliance with her medication. Patient states that she went to dialysis center for her regular dialysis and her blood pressure was elevated with systole reading of over 200.

NURSING INTERVENTIONS

1. Auscultate breath sounds for presence of crackles, wheezes or rhonchi.

2. Restrict sodium and fluid intake to lessen fluid retention and overload.

1. Note status and change and review lab results such as BUN, creatinine levels and serum electrocytes.

2.Montior blood pressure for patient's baseline and usual range.