

CARE OF THE PATIENT WITH CHRONIC KIDNEY DISEASE, STAGES 1-4

OBJECTIVES:

1. To maintain fluid/electrolyte balance.
2. To achieve and maintain blood pressure within targeted range.
3. To decrease the rate of progression of chronic kidney disease (CKD).
4. To reduce modifiable risk for cardiovascular disease (CVD).
5. To educate the patient on fluid balance and its implications.

PROCESS STANDARDS:

1. Vital signs will be taken a minimum of every eight (8) hours and abnormal signs will be reported to the physician.
2. Intake and output will be monitored and documented every hour until output exceeds 30 ml/hour, then every four (4) hours.
3. Urine color and characteristics will be documented and any changes will be reported to the physician.
4. Patient will be assessed for peripheral edema and/or pulmonary edema at least every eight (8) hours.
5. Patient will be weighed daily before breakfast and weight will be recorded.
6. Significant abnormal lab values will be documented and reported to the physician.
7. Patient/significant other will be instructed in disease process, treatment regimen including medication and fluid/dietary restrictions.

OUTCOME STANDARDS:

At the time of discharge:

1. The patient will have adequate renal function or appropriate alternate therapy prior to discharge.
2. The patient/significant other will express understanding of disease process, treatment regimen, and fluid/dietary restrictions.
3. Patient will recognize risk factors that exacerbate problem and changes lifestyle appropriately.

Standard 23

Revised: 2003, 2006

Reviewed: 1991, 1994, 1997, 2000, 2009

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HAVE I DOCUMENTED:

- * Lab Values
- * Vital signs every 8 hours
- * Monitoring of fluid balance
 - I&O
 - Daily weight
 - Peripheral edema
- * Skin integrity
- * Respiratory assessment
 - Rate
 - Pulmonary edema
- * Cardiac assessment
 - Rate
 - Rhythm
- * Psychological status
 - Anxiety
 - Disturbance in self-concept
 - Fear of death
- * Patient education
 - Disease Process
 - Procedures
 - Home management
 - Consult for diet instruction (Renal Diet)

At the time of Discharge:

- * Ability to assume care at home
- * Patient/family has understanding of home and follow-up care
 - Complication management
 - Medication
 - When to call physician
 - Dietary restrictions

Reference:

1. Burrows-Hudson, S., Prowant, B. (2005). ANNA Nephrology Nursing Standards of Practice and Guidelines for Care, pp 19-30. Pitman, New Jersey: Anthony J. Jannetti, Inc.