|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment: Client Data** *(What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)* | Nursing Diagnosis Statement(NANDA Approved) | | |
| ***Subjective Data:*** *(What did the client say about the issue?)* | ***NANDA Label:***  Excess Fluid Volume  *Definition: surplus intake and/or retention of fluid.* | | ***Priority According to Maslow:***  *(circle one)*  ***HIGH***  ***MEDIUM***  ***LOW*** |
| ***Objective Data: (****What information, [lab values, vital signs, etc.] do you have about the issue?)* | ***Related to:*** *(Etiology: Pick one. This is what you will develop the outcome to address.)*   * Excessive fluid intake * Excessive sodium intake * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| ***As Manifested by:*** *(These are the* ***signs and/or symptoms*** *that prove the NANDA Label is a problem.)* | | |
| **Planning: Client Outcome** |  | | |
| ***Outcome*** *(Only one behavior/response. Needs to be specific, observable, measureable, achievable, realistic and timed for THIS client.)* | | ***Time*** *(When you expect the response to occur. If there is an agency policy for reassessment, such as with pain, utilize that time frame in your outcome to add it to your workflow.)* | |
| **The client will:**   * Remain free of edema, effusion, anasarca * Maintain body weight appropriate for the client * Maintain clear lung sounds; no evidence of dyspnea or orthopnea * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Daily * Every 4/ 8/ 12/ 24/ hrs. *(circle one)* * by discharge / transfer *(circle one)* * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |
| --- | --- |
| **PLANNING:** **Interventions** *(Select interventions that help the client achieve the outcome. Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.)* | **IMPLEMENTATION:** *(****Document how you implemented the intervention and the client’s response*** *If you were unable to implement the intervention, state that, and why.)* |
| * Monitor location and extent of edema using the 1+ to 4+ scale to quantify edema; also measure the legs using a millimeter tape in the same area at the same time each day. Note differences in measurement between extremities. *Numerous studies in patients and in experimental models of congestive heart failure (CHF) have established the important role of the renin–angiotensin–aldosterone system (RAAS) and the sympathetic nervous system (SNS) in the progression of cardiovascular and renal dysfunction in CHF. It is now accepted that excessive neurohormonal activation may adversely affect cardiac function and the hemodynamic condition by enhancement of systemic vasoconstriction and promoting salt and water retention by the kidney (* [Zaher et al, 2020](https://coursewareobjects.elsevier.com/objects/elr/Ackley/NDH12e/careplanconstructor/careplan_102.php#bib11.21)*).* |  |
| * Monitor daily weight for sudden increases; use same scale and type of clothing at same time each day, preferably before breakfast**.***Body weight changes reflect changes in body fluid volume.* *Body weight is commonly used to monitor for fluid overload (* [Wagner & Hardin-Pierce, 2014](https://coursewareobjects.elsevier.com/objects/elr/Ackley/NDH12e/careplanconstructor/careplan_102.php#bib11.16)*).* |  |
| * Monitor intake and output; note trends reflecting decreasing urine output in relation to fluid intake. *Abnormally low urine output (oliguria) is a leading indicator of acute kidney injury (AKI), which increases mortality, cost of care, and length of stay (* [Yong et al, 2013](https://coursewareobjects.elsevier.com/objects/elr/Ackley/NDH12e/careplanconstructor/careplan_102.php#bib11.20)*).* |  |
| * Chronic HF is characterized by neurohormonal activation and sodium retention that leads to excessive fluid accumulation in the systemic and pulmonary circulations. *Monitor vital signs; note decreasing blood pressure, tachycardia, and tachypnea. Monitor for S3 heart sounds. If signs of HF are present, see the care plan for* *Decreased****Cardiac****output* *.* |  |
| * Auscultate lung sounds for crackles, monitor respiration effort, and determine the presence and severity of orthopnea. *The pulmonary system adapts to the increased post CVP, which is believed to be caused by reduced capillary filtration from pulmonary basal membrane thickening, enhanced alveolar fluid clearance, and increased lymphatic drainage (* [Melenovsky, 2015](https://coursewareobjects.elsevier.com/objects/elr/Ackley/NDH12e/careplanconstructor/careplan_102.php" \l "bib11.8)*).* |  |
|  |  |
| **EVALUATION of OUTCOME: (*Documented in a Nurse’s Note)*** | |
|  | |
|  | |
|  | |
|  | |