

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	INFERENCE	PLANNING	INTERVENTION	RATIONALE	EVALUATION
<p>SUBJECTIVE:</p> <p>"Namamanas ang kanang binti ng anak ko" (My son has a massive edema on his lower right leg) as verbalized by the mother.</p> <p>OBJECTIVE:</p> <ul style="list-style-type: none"> • Edema • Weight gain • Changes in vital signs • V/S taken as follows: <p>T: 37.3 P: 85 R: 21</p>	<p>Excess fluid volume related to compromised regulatory mechanism with changes in hydrostatic or oncotic vascular pressure and increased activation of the rennin-angiotensin-aldosterone system.</p>	<p>Nephrotic syndrome is a clinical disorder of unknown cause characterized by proteinuria, hypoalbuminemia, edema, and hyperlipidemia. This conditions result from excessive leakage of plasma proteins into the urine because of impairment of the glomerular capillary membrane.</p>	<ul style="list-style-type: none"> • After 8 hours of nursing interventions, the patient will display stable weight, vital signs within patient's normal range, and nearly absence of edema. 	<p>INDEPENDENT:</p> <ul style="list-style-type: none"> • Record accurate intake and output of the patient. • Monitor urine specific gravity. • Weigh daily at same time of the day, on same scale, with same equipment and clothing. • Assess skin, face, dependent areas of edema. 	<ul style="list-style-type: none"> • Accurate Intake and output is necessary for determining renal function and fluid replacement needs and reducing risk of fluid overload. • Measures the kidney's ability to concentrate urine. • Daily body weight is the best monitor of fluid status. A weight gain of more than 0.5 kg/day suggest fluid retention. • Edema occurs primarily in dependent tissues of the body. It will serve as parameter the 	<ul style="list-style-type: none"> • After 8 hours of nursing interventions, the patient was able to display stable weight, vital signs within patient's normal range, and nearly absence of edema.

Nursing Care Plans Nursing Diagnosis And Intervention

Meg Gulanick



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Table of Contents Nursing Care Plans Nursing Diagnosis And Intervention

1. Understanding the eBook Nursing Care Plans Nursing Diagnosis And Intervention
 - The Rise of Digital Reading Nursing Care Plans Nursing Diagnosis And Intervention
 - Advantages of eBooks Over Traditional Books
2. Identifying Nursing Care Plans Nursing Diagnosis And Intervention
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Nursing Care Plans Nursing Diagnosis And Intervention
 - User-Friendly Interface
4. Exploring eBook Recommendations from Nursing Care Plans Nursing Diagnosis And Intervention

- Personalized Recommendations
 - Nursing Care Plans Nursing Diagnosis And Intervention User Reviews and Ratings
 - Nursing Care Plans Nursing Diagnosis And Intervention and Bestseller Lists
5. Accessing Nursing Care Plans Nursing Diagnosis And Intervention Free and Paid eBooks
 - Nursing Care Plans Nursing Diagnosis And Intervention Public Domain eBooks
 - Nursing Care Plans Nursing Diagnosis And Intervention eBook Subscription Services
 - Nursing Care Plans Nursing Diagnosis And Intervention Budget-Friendly Options
 6. Navigating Nursing Care Plans Nursing Diagnosis And Intervention eBook Formats
 - ePub, PDF, MOBI, and More
 - Nursing Care Plans Nursing Diagnosis And Intervention Compatibility with Devices
 - Nursing Care Plans Nursing Diagnosis And Intervention Enhanced eBook Features
 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Nursing Care Plans Nursing Diagnosis And Intervention
 - Highlighting and Note-Taking Nursing Care Plans Nursing Diagnosis And Intervention
 - Interactive Elements Nursing Care Plans Nursing Diagnosis And Intervention
 8. Staying Engaged with Nursing Care Plans Nursing Diagnosis And Intervention
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Nursing Care Plans Nursing Diagnosis And Intervention
 9. Balancing eBooks and Physical Books Nursing Care Plans Nursing Diagnosis And Intervention
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Nursing Care Plans Nursing Diagnosis And Intervention
 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
 11. Cultivating a Reading Routine Nursing Care Plans Nursing Diagnosis And Intervention
 - Setting Reading Goals Nursing Care Plans Nursing Diagnosis And Intervention
 - Carving Out Dedicated Reading Time
 12. Sourcing Reliable Information of Nursing Care Plans Nursing Diagnosis And Intervention

- Fact-Checking eBook Content of Nursing Care Plans Nursing Diagnosis And Intervention
- Distinguishing Credible Sources

13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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