Edema Nursing Care Plan

Patient Information Name: Age: Gender: Medical History: Date of Admission: **Assessment** • Description of Edema (location, extent, type): • Vital Signs (BP, HR, RR, Temp): • Relevant Lab Values (e.g., electrolytes, kidney function): • Associated Symptoms (e.g., pain, difficulty breathing): • Potential Contributing Factors (e.g., heart failure, renal issues, medication side effects): **Nursing Diagnosis** • Primary Diagnosis related to edema: Contributing Factors/Related to: • Evidence/As evidenced by:

Planning:

• Short-Term Goals (e.g., reduce swelling in X days):

Long-Term Goals (e.g., manage underlying cause, prevent recurrence):
Patient Education Goals:
Interventions:
Monitoring (e.g., vital signs, fluid balance):
Medication Administration (e.g., diuretics, pain relief):
Dietary Modifications (e.g., sodium restriction):
 Activity Recommendations (e.g., elevation of limbs, compression stockings):
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Patient Education (e.g., self-care techniques, medication management):
Implementation:
Detailed steps for each intervention:
Delegation of responsibilities (if applicable):
Coordination with other healthcare professionals:

Evaluation

Response to Interventions (e.g., reduction in swelling):
Progress towards Goals:
Need for Plan Modification:
Patient/Family Feedback:
Documentation
Record of care provided:
Changes in patient condition:
Patient's response to interventions:
Doctor's Signature:
Name (Print):
Date:

This template is a general guide and should be adapted to fit the specific needs and circumstances of each patient. It's important to regularly review and update the care plan based on the patient's condition and response to treatment.