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Digoxin monitoring Comfort & daily function

Pharmacology-related Cases | Comfort & daily function

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

73-year-old woman taking digoxin for a defined cardiac indication. Care stage: During supported recovery and essential daily activity.

Medical history: Digoxin is prescribed for a cardiac indication. New nausea, appetite loss and visual symptoms prompted assessment for treatment-related toxicity. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Nausea, poor appetite and new visual disturbance.

Objective findings and required checks: Pulse/rhythm, renal function and electrolyte assessment are needed; toxicity is suspected.

Physical examination and investigations: Review ECG, pulse, renal function, potassium/magnesium, medicine history and timed drug level when ordered.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Digoxin monitoring: Digoxin affects cardiac conduction and contractility; reduced clearance or electrolyte changes can increase toxicity.

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Medical / surgical management

Escalate possible toxicity, follow authorized hold instructions and prepare prescribed monitoring or treatment.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Digoxin	Treat the specific cardiac indication	Monitor rhythm, renal function, electrolytes and toxicity symptoms
prescribed antidote in selected toxicity	Manage a specialist-defined emergency	Use the authorized treatment pathway.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Nausea, poor appetite and new visual disturbance. Pulse/rhythm, renal function and electrolyte assessment are needed; toxicity is suspected. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize possible treatment-related harm requiring prompt assessment; reduced circulation to vulnerable tissues; nutritional intake below current needs; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

During the next agreed care or activity session: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Escalate possible toxicity, follow authorized hold instructions and prepare prescribed monitoring or treatment. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This

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vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about medicine names, timing, symptoms and non-prescribed products. Assess: Review observations, medication record and relevant drug-specific investigations.	Possible treatment-related harm requiring prompt assessment. Possible factors: adverse medication effects or an administration problem. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: The suspected adverse event is escalated and no further avoidable exposure occurs. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the revised medication plan and warning symptoms before discharge.	1. Assess airway, breathing, circulation and the time course of symptoms. Rationale: Serious adverse reactions require immediate stabilization. 2. Escalate suspected toxicity and follow the authorized hold, monitoring or antidote instructions. Rationale: Treatment decisions depend on the drug and clinical severity. 3. Document and communicate the reaction and reconcile the medicine list. Rationale: Accurate records reduce repeat exposure and support pharmacovigilance. 4. Escalate possible toxicity, follow authorized hold instructions and prepare prescribed monitoring or treatment. Rationale: Digoxin affects cardiac conduction and contractility; reduced clearance or electrolyte changes can increase toxicity. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about dizziness, chest discomfort, fatigue and cold extremities. Assess: Assess consciousness, pulse, blood pressure, capillary refill and urine trend.	Reduced circulation to vulnerable tissues. Possible factors: altered blood flow or cardiac function. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Circulation and consciousness remain within the clinician-agreed targets. Longer-term: Before the clinically approved transition or agreed follow-up: Describes symptoms that require immediate review and the agreed follow-up plan.	1. Trend perfusion findings and escalate new chest pain, shock or altered consciousness immediately. Rationale: Poor circulation can rapidly threaten organ function. 2. Balance activity and rest and maintain the ordered monitoring schedule. Rationale: Reducing demand supports recovery while trends guide treatment. 3. Administer prescribed therapy and monitor effects and adverse reactions. Rationale: Response monitoring supports safe correction of the underlying problem.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about usual diet, recent intake, weight change and food access. Assess: Assess growth or weight trends, intake record and relevant nutritional findings.	Nutritional intake below current needs. Possible factors: poor appetite, increased requirements or feeding difficulty. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Tolerates the agreed nutrition plan without new complications. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the individualized meal or feeding plan and follow-up arrangements.	1. Assess nutritional risk and confirm swallowing safety and any fasting order. Rationale: The appropriate feeding route depends on clinical safety. 2. Offer suitable small meals or prescribed feeds with dietitian input when indicated. Rationale: Individualized support improves intake and nutrient adequacy. 3. Monitor tolerance, weight or growth and metabolic findings where required. Rationale: Progress and complications guide adjustment of support.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: During the next agreed care or activity session: Explains the most	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach exact dosing, avoiding duplication, interaction checks and early toxicity reporting. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach exact dosing, avoiding duplication, interaction checks and early toxicity reporting.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Arrhythmia, syncope, marked bradycardia, hyperkalemia concern or reduced consciousness requires urgent review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Digoxin affects cardiac conduction and contractility; reduced clearance or electrolyte changes can increase toxicity.

- Priority concerns: Possible treatment-related harm requiring prompt assessment; Reduced circulation to vulnerable tissues; Nutritional intake below current needs; Learning needs about the condition and care plan.

- Arrhythmia, syncope, marked bradycardia, hyperkalemia concern or reduced consciousness requires urgent review.

- Teach exact dosing, avoiding duplication, interaction checks and early toxicity reporting.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

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