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# Heart failure Comfort & daily function

Adult Health Nursing | 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

68-year-old woman with worsening congestion. Care stage: During supported recovery and essential daily activity.

Medical history: Known heart failure is followed by increasing swelling and orthopnea during the current episode. The prescribed medicine and recent weight records need reconciliation. 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: Breathlessness lying flat, leg swelling and recent weight gain.

Objective findings and required checks: Dependent edema and basal crackles; perfusion and renal status require monitoring.

Physical examination and investigations: Review ECG, renal function, electrolytes, chest imaging and echocardiography when ordered.

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

## Clinical focus and pathophysiology

Heart failure: Reduced cardiac function and neurohormonal responses can cause congestion and impaired organ perfusion.

## Medical / surgical management

Monitor breathing, weight and fluid balance; implement prescribed medicines and individualized activity and fluid advice.



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## Illustrative drug and treatment study

| Medicine / treatment | Purpose | Nursing checks |
|---|---|---|
| Furosemide | Relieve prescribed congestion | Monitor urine, blood pressure, electrolytes and renal function |
| prescribed heart-failure therapy | Support long-term cardiac management | Verify the exact regimen and monitoring. |

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

## Nursing process - ADPIE

### Assessment

Breathlessness lying flat, leg swelling and recent weight gain. Dependent edema and basal crackles; perfusion and renal status require monitoring. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

### Nursing diagnosis

Prioritize fluid accumulation affecting comfort or function; breathing difficulty affecting oxygenation; reduced circulation to vulnerable tissues; 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

Monitor breathing, weight and fluid balance; implement prescribed medicines and individualized activity and fluid advice. 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 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 breathlessness, swelling and recent weight gain. Assess: Monitor edema, respiratory findings, weight, intake/output and electrolytes. | Fluid accumulation affecting comfort or function. Possible factors: impaired fluid handling or excess retention. Validate against the patient's assessment. | Short-term: During the next agreed care or activity session: No progression of respiratory distress or edema occurs during the observation period. Longer-term: Before the clinically approved transition or agreed follow-up: Explains prescribed fluid, salt, weight-monitoring and follow-up instructions. | 1. Use consistent weighing and intake/output records. Rationale: Comparable measurements help identify fluid trends. 2. Assess respiratory changes and elevate the head of the bed if tolerated. Rationale: Pulmonary fluid accumulation may compromise breathing. 3. Implement only prescribed fluid limits and diuretic treatment; monitor renal function and electrolytes. Rationale: Treatment must balance fluid removal with circulation and electrolyte safety. 4. Monitor breathing, weight and fluid balance; implement prescribed medicines and individualized activity and fluid advice. Rationale: Reduced cardiac function and neurohormonal responses can cause congestion and impaired organ perfusion. 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 breathlessness, chest tightness and activity tolerance. Assess: Record respiratory rate, effort, SpO2 and mental state against the prescribed target. | Breathing difficulty affecting oxygenation. Possible factors: altered ventilation or gas exchange. Validate against the patient's assessment. | Short-term: During the next agreed care or activity session: Breathing effort improves and oxygenation remains within the individualized target. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the respiratory action plan and demonstrates the prescribed device technique. | 1. Reassess work of breathing and response to each intervention. Rationale: Trend changes identify deterioration earlier than a single reading. 2. Position to ease breathing, cluster care and allow rest. Rationale: This can reduce respiratory demand and distress. 3. Give oxygen and respiratory medicines only according to the clinical prescription or emergency protocol. Rationale: Individualized treatment supports oxygenation without unsafe blanket targets. | 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 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 what the learner already knows and wants to | Learning needs about the condition and care plan. Possible | Short-term: During the next agreed care or activity session: | 1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves | Record the baseline and reassessed |



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| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| understand. Assess: Use teach-back or demonstration to identify specific gaps. | factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment. | Explains the most 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. | understanding. 2. Teach a few 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 daily weight monitoring when advised, medicine adherence, salt/fluid instructions and early symptom reporting. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care. | 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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## Health education and continuing care

Teach daily weight monitoring when advised, medicine adherence, salt/fluid instructions and early symptom 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

**Acute severe breathlessness, chest pain, shock or reduced consciousness requires emergency 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

- Reduced cardiac function and neurohormonal responses can cause congestion and impaired organ perfusion.

- Priority concerns: Fluid accumulation affecting comfort or function; Breathing difficulty affecting oxygenation; Reduced circulation to vulnerable tissues; Learning needs about the condition and care plan.

- Acute severe breathlessness, chest pain, shock or reduced consciousness requires emergency review.

- Teach daily weight monitoring when advised, medicine adherence, salt/fluid instructions and early symptom reporting.

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

## References

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