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Breathing difficulty affecting oxygenation Heart failure

Adult Health Nursing | Focused diagnosis-based template

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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.

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.

Illustrative drug and treatment study

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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.

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Focused nursing-problem template

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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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, 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: At the next patient-specific reassessment: 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. 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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: Breathing difficulty affecting oxygenation.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Health Alterations - Open RN / WisTech Open, 2025
https://wtcs.pressbooks.pub/healthalts/

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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

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