

**Type: Research Paper**  
**Subject: Evidenced based research**  
**Subject area: Nursing**  
**Education Level: Undergraduate/College**  
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**Referencing style: APA**  
**Preferred English: US English**  
**Spacing Option: Double**

**Title: Nursing Management of Congestive Heart Failure**

**Instructions: apa format 7th edition use the concept of perfusion and evidence-based practice no need for patient data sheet or medication sheet use the patient from the case study attached +see files attached (syllabus pg 20-21 & case study)**

Student's Name

Professor's Name

Institution

Course

Date



**What data from the histories are RELEVANT and must be interpreted as clinically significant by the nurse?**

(Reduction of Risk Potential)

<b>RELEVANT Data from Current Problem:</b>	<b>Clinical Significance:</b>
<p>The age of the patient is a relevant data that needs to be picked during a medical attention. The weight of the patient is also important to note during a physician assessment. It is also critical to note the patient's medical history. Smith suffers type II diabetes, Myocardial infraction, hypertension and chronic systolic heart failure.</p>	<p>The age of the patient guides a clinician in determining the appropriate medication for the patient. The age also helps ascertain the reasons for some of the conditions a patient exhibit. The weight of the patient guides the physician in prescribing the medication and in determining the possible cause of the disease. The medical history of a patient helps to know the possible reasons for the condition, guide in the medication prescription to avoid redundancy and to help eliminate possible risks in medical reactions.</p>
<b>RELEVANT Data from Inpatient Admission:</b>	<b>Clinical Significance:</b>
<p>The relevant information in this area includes the symptoms the patient presents to the physician. the aspect of weakness, fatigue, low tolerance to activity and shortness of breath are some of the identified elements. It is also appropriate to note that the patient has already been administered with Furosemide IV. Also, the patient is at his baseline weight before being discharged.</p>	<p>The signs presented by the patient helps the nurse to determine the possible diagnosis. The elements mentioned help note the possible causes of the combination of symptoms (Inamdar &amp; Inamdar, 2016). The administered medication upon admission is also important. This helps determine whether the intervention was effective or it needs to be changed. The baseline weight is important information that informs the nurse that the patient has showed positive response.</p>
<b>RELEVANT Data from Re-Hosp. Risk</b>	<b>Clinical Significance:</b>

Assess:	
<p>The relevant information includes the fact that the patient was readmitted within the last 30 days. The patient complains of decompensated heart failure. Upon discharge, the patient had pulmonary edema and exacerbation of chronic systolic heart failure. A home-based follow-up by a registered nurse was recommended. Issues of medical adherence were cited and management of heart failure.</p>	<p>The fact that the patient was readmitted within 30 days shows a nurse that there is possibility that the medication was ineffective. The issue of decompensated heart failure on the second admission informs a physician the possible reasons for this persistent issue. the diagnosis of pulmonary edema and chronic systolic heart failure sends a clinical message that there are other underlying issues that promote the readmission (Ziaei &amp; Fonarow, 2016). The issues of medical adherence and management of heart failure informs the possible reasons for the home-based follow-up recommended. These show that the patient might have issues with the adherence or the management of the disease. The follow-up can help the nurse determine the feasibility of the case and recommend the best appropriate measures that can be adopted to avoid readmission.</p>

**What data from the social history are RELEVANT and must be interpreted as clinically significant by the nurse? (Reduction of Risk Potential)**

RELEVANT Data from Social History:	Clinical Significance:
<p>The wife dies one year ago. Smith has lost his activity moods and he isolates himself inside the house. He lives alone as the children and grandchildren live far away from the home. He eats frozen meals that needs heating and can foods.</p>	<p>The information is critical to guide the nurse to know some of the reasons he suffers these illnesses and how this state of living can be managed. The can and frozen foods are also important information as the nurse knows that there is a need to eliminate this lifestyle as it significantly contributes to the issue of overweight.</p>

**Lab Results: Prior to Discharge**

<b>Cardiac Labs:</b>	<b>Prior to Discharge:</b>	<b>High/Low/WNL?</b>
BNP (B-natriuretic Peptide) (<100 ng/L)	1210	high

**What lab results are RELEVANT and must be recognized as clinically significant by the nurse?**

(Reduction of Risk Potential/Physiologic Adaptation)

<b>RELEVANT Lab(s):</b>	<b>Clinical Significance:</b>	<b>TREND:</b> <b>Improve/Worsening/Stable:</b>
The BNP level of the patient is an important information that the nurse needs to capture.	The levels can show the nurse the signs of a heart failure in the patient. A normal BNP is anything less than 300 for any age bracket.	The levels shows that the patient is in a worst position. The level is way higher than the normal and for the age bracket, Smith risks a possible heart failure.

<b>Basic Metabolic Panel (BMP)</b>	<b>Prior to Discharge:</b>	<b>High/Low/WNL?</b>
Sodium (135–145 mEq/L)	145	Normal
Potassium (3.5–5.0 mEq/L)	3.5	Normal
Glucose (70–110 mg/dL)	200	High
Creatinine (0.6–1.2 mg/dL)	1.0	Normal

**What lab results are RELEVANT and must be recognized as clinically significant by the nurse?**

(Reduction of Risk Potential/Physiologic Adaptation)

<b>RELEVANT Lab(s):</b>	<b>Clinical Significance:</b>
The lab results for glucose level are important owing to the health history of the patient that warrants the level of glucose to be monitored.	The levels of glucose are critical for a diabetic patient and for a patient with a heart condition. the high level of glucose in the body proves to be a significant issue that the nurse has to capture to be sure to help the patient manage the level and maintain a healthy diet.

**Review the home medications with the current discharge orders. Are there any discrepancies that**

**the nurse needs to clarify with the primary care provider? (Pharmacologic and Parenteral**

**Therapies)**

Home Medications:	Discharge Medications:	List any Discrepancies from Home Meds and how were they reconciled:
<ul style="list-style-type: none"> <li>● Lisinopril 20 mg PO daily</li> <li>● Furosemide 80 mg PO daily</li> <li>● Metoprolol 50 mg PO twice daily</li> <li>● Digoxin: 0.125 mg PO daily</li> <li>● Hydralazine 25 mg PO 4 times a day</li> <li>● Glipizide 10 mg PO twice daily before meals.</li> </ul>	<ul style="list-style-type: none"> <li>● Lisinopril 20 mg PO daily</li> <li>● Furosemide 80 mg PO daily. Take additional 80 mg tab if 3 lbs. or more weight gain and call MD</li> <li>● Metoprolol ER 100 mg PO daily</li> <li>● Digoxin: 0.125 mg PO daily</li> <li>● Hydralazine 25 mg PO 4 times a day</li> <li>● Glipizide 10 mg PO twice daily before meals.</li> <li>● Potassium chloride 20 mEq PO daily</li> </ul>	<p>Furosemide was prescribed with an overdose for the discharge medications. On home medication, it was recommended to eliminate additional 80mg tab</p> <p>Metoprolol was administered on an overdose of 100mg, taken once for the discharge medication. On home medication, the medication was recommended for 50mg twice a day to</p> <p>On the discharge medication, the patient medication was reviewed chloride 20mEq PO every day, which was eliminated for the home medications.</p>

*List each current medication from discharge and reconciled lists and answer the following:*

*(Pharmacologic and Parenteral Therapies)*

Home Medications:	Pharmacologic Class:	Mechanism of Action and indication:	Expected Response/Benefit:	Patient ed & Nsg. Interventions

Lisinopril 20 mg PO daily	Angiotensin-converting enzyme (ACE) inhibitors	Reduces the chemicals that tighten the blood vessels	Allows blood to flow smoothly	Monitor the blood pressure to determine effectiveness.
Furosemide 80 mg PO daily. Take additional 80 mg tab if 3 lbs. or more weight gain and call MD	diuretics ('water pills')	inhibition of the sodium-potassium-2 chloride ( $\text{Na}^+\text{-K}^+\text{-2 Cl}^-$ ) co-transporter (symporter)	Eliminates the fluid build-up	Patient to learn the different ways it can be administered
Metoprolol ER 100 mg PO daily	Beta blockers	Relaxes blood vessels and slows heart rate	Improves blood flow and reduces blood pressure	Patient should take the right quantity before or after meals
Hydralazine 25 mg PO 4 times daily	vasodilators	Relaxes the blood vessels	Blood flows easy and smooth	Patient should learn to take medication same time everyday
Glipizide 10 mg PO twice daily before meals	sulfonylureas	Reduces blood sugar	Triggers pancreas to produce insulin and helps the body to use it efficiently	Patient should monitor the insulin levels and learn how to administer the medication efficiently
Potassium chloride 20 mEq PO daily	electrolytes	Prevents and treat low blood levels	Helps body to function normally	Patient should learn what types of foods or products to take to maintain the levels of potassium in the body
Digoxin: 0.125 mg PO daily	digitalis glycosides	Improves strength and efficiency of the heart.	Attains normal heart rate and rhythm	Patient to learn how to take the medication. Best taken without food.

**Medical Management** (including Pharmacologic and Parenteral Therapies)

Home Care Orders:	Rationale:	Expected Outcome:
Initiate Home Health Care	This should ensure the patient has a better medication	Patient experiences

Services	adherence and efficient disease management. it also allows close monitoring of the patient to ascertain their condition improves gradually.	better health and reduces chances of readmission
2 g low sodium diet	Low sodium diet is critical to control the heart failure symptoms of the patient.	Limited amounts of fluid around the heart, lungs and legs.
Fluid restriction of 2000 mL PO daily	Fluid restriction ensures that the patient does not have excess fluids that compromise the heart condition	Regulated fluids around the heart
Basic metabolic panel (BMP) ordered in one week	This provides information about how the body uses energy.	Helps evaluate the kidney function and blood sugar.

### Part I: Home Assessment:

*What data from the INITIAL home assessment and patient response are RELEVANT and must be interpreted as clinically significant by the nurse? (Reduction of Risk Potential)*

<b>RELEVANT Data from Home Assessment:</b>	<b>Clinical Significance:</b>
<p>The patient lives alone, avoids cooking and consumes a lot of takeout food. He forgets prescriptions and tend to consume old medications when unable to pick a refill. He has issues with co-pays.</p>	<p>The fact that the patient lives alone give a nurse a preview of what his life looks like on a daily and how this can affect his medication and health. Forgetting prescription doses informs the nurse that the patient may have interfered with the medication cycle, which renders the medication he takes ineffective. Takeout foods explain to the nurse why the patient might be gaining weight often and the unhealthy lifestyle that informs the diabetic condition. the co-pays in the medication informs the nurse that the patient may be avoiding refills due to financial constraints.</p>

<b>RELEVANT Data from Patient Response:</b>	<b>Clinical Significance:</b>
<p>The passing of the wife was unexpected and she was the one who took care of the cooking and grocery in the house. Patient consumes ready-to-eat foods because he does not want to spend time in the kitchen. Smith experiences less activity over the year and feels depressed. He forgets to weigh himself because of inability to read the scale. Smith is open to home services.</p>	<p>The sudden death of the wife explains why the patient is depressed and isolates himself often. Smith is unable to take healthy foods because of the wife's death, which gives the nurse a preview of some of the behaviors that he needs to change (Houlden, Yen &amp; Mirrahimi, 2017). The less activity explains the weight gain and the abdominal distension, which are unhealthy for the patient. The abdominal distension also tells why he forgets to weigh himself and informs the nurse why the patient experiences challenges with monitoring weight and continuously eating takeout foods.</p>

<b>Functional Limitations:</b>	<b>Fall Risk Assessment:</b>
<p>The patient experiences less activity and spends most time on the house. The fact that the abdominal distension prevents him from reading the scale shows that it also limits him from engaging in other activities.</p>	<p>The fact that the house is cluttered shows the possibility that Smith might trip and fall off in the house. The overweight nature of the patient informs a nurse that in case of a fall risk, the patient might be unable to independently get up.</p>

## **Part II: Collecting Clinical Data:**

***What VS data are RELEVANT and must be interpreted as clinically significant by the nurse?***

*(Reduction of Risk Potential/Health Promotion and Maintenance)*

<b>RELEVANT Data:</b>	<b>Clinical Significance:</b>	<b>Green-Yellow-Red Zone:</b>
<p>The blood pressure is a vital sign that needs to be captured</p>	<p>The blood pressure is critical sign that informs the nurse the possible risks the patient is facing at the particular time.</p>	<p>Yellow zone</p>

***What assessment data is RELEVANT and must be interpreted as clinically significant by the nurse?***

*(Reduction of Risk Potential/Health Promotion & Maintenance)*

<b>RELEVANT Data:</b>	<b>Clinical Significance:</b>	<b>Green-Yellow-Red Zone:</b>
Based on the current medication, the cardiac assessment is critical.	The patient has history of heart conditions that warrants the cardiac assessment. This informs the nurse whether the histories are still a potential risk and how the patient care plan can be efficiently drafted.	Green zone

*Is ambiguity (findings that are not normal) of clinical data present? If present, is it acceptable based on this patient's history or is it a priority concern?*

<b>AMBIGUITY of Clinical Data:</b>	<b>Acceptable or Concern/Why?</b>
There is ambiguity in the clinical data reported.	There is a concern considering the current medication the patient is prescribed in the home-based care. The nurse should consider reviewing the list of medication to determine if the patient needs all of them or that there is part of the results that do not show accurate data.

### **Part III: Put it All Together to Think Like a Home Health Nurse!**

*1. Interpreting relevant clinical data, what is the primary problem? What primary health-related concepts does this primary problem represent? (Management of Care/Physiologic Adaptation)*

<b>Problem:</b>	<b>Pathophysiology of Problem in OWN Words:</b>	<b>Primary Concept(s):</b>
The patient is unable to live healthy lifestyle, and this compromises his general health and	The nature of the assessments shows that the patient fails to appreciate a healthy living. The types of foods he consumes are a major contribution to the health issues he faces. The patient further limits his activities which makes him isolated, and prevents him from exercising to cut down weight. Such	The primary concepts in the case is lifestyle, and patient behaviors as these affect the health and

well-being.	problems contribute to the type II diabetes, heart condition and overweight.	well-being of the patient.
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**2. What nursing priority (ies) will guide your plan of care? (Management of Care)**

<b>Nursing PRIORITY:</b>	Promote self-care	
<b>PRIORITY Nursing Interventions:</b>	<b>Rationale:</b>	<b>Expected Outcome:</b>
Patient Education	The patient needs education on how he can promote a healthy living and eliminate some of the issues that prove to be a compromise of the general health. The education also includes medication adherence to ensure the patient acknowledges the importance of taking the right dosages and refilling medicine when they deplete.	Gradual recovery and elimination of chances for readmission.

**3. What body system(s) will you assess most thoroughly based on the primary/priority concern?**

*(Reduction of Risk Potential/Physiologic Adaptation)*

<b>PRIORITY Body System:</b>	<b>PRIORITY Nursing Assessments:</b>
The heart system. This is the main body system that shows high risks for the patient.	The patient suffers possible heart failures, which risks death is not addressed immediately (Packer, 2020). The lifestyle and behaviors of the patient proves to be inefficient in handling this condition and thus, needs education and guidance on how the heart condition can be monitored and kept on track.

**4. What is the worst possible/most likely complication(s) to anticipate based on the primary problem of this patient?**

*(Reduction of Risk Potential/Physiologic Adaptation)*

<b>Worst Possible/Most Likely Complication to Anticipate:</b>	Heart Failure, risking death	
<b>Nursing Interventions to PREVENT this Complication:</b>	<b>Assessments to Identify Problem EARLY:</b>	<b>Nursing Interventions to Rescue:</b>
Emphasize on adherence to medication and increase rates of activity in the daily life operations. the medications will address the heart condition and eliminate the problem.	Regularly monitoring of heart rates and rhythm to ascertain the patient is well and keeps up with the medication and self-care.	Patient education to ensure the medications are strictly adhered and that the patient manages the condition effectively.

**5. What psychosocial/holistic care PRIORITIES need to be addressed for this patient?**

*(Psychosocial Integrity/Basic Care and Comfort)*

<b>Psychosocial PRIORITIES:</b>	Isolation and levels of activities	
<b>PRIORITY Nursing Interventions:</b>	<b>Rationale:</b>	<b>Expected Outcome:</b>
The nurse should encourage the patient to go out and break the isolation mode that has already been set.  Encourage patient to engage in more activities to counter the weight gain.	The patient is depressed and isolated, a reason his lifestyle is compromised. Going out and socialize with other people will give the patient reason to view the world from a different perspective, heal from the death of wife and start taking life with a degree of seriousness. Going out also increases the levels of activity that the patient needs, to counter the overweight and find time for the groceries.	Excellent mental state and managed weight. The takeout foods will also be less consumed.

**6. How will the nurse assess what this patient already knows about their primary problem and**

*identify knowledge gaps?*

The nurse can interview the patient on some of the important aspects noted about the health. The responses given by the patient will determine whether the patient is aware of the primary issues and note the knowledge gaps that exist.

**7. *What educational priorities will guide the development of a teaching plan for this patient and/or family?***

*(Health Promotion and Maintenance)*

<p><b>Education PRIORITY</b> (What patient needs to know to prevent readmission):</p>	<p>Medication adherence; Self-care management</p>
<p><b>PRIORITY Topics to Teach</b> (What tools can you use if available?):</p>	<p><b>Rationale:</b></p>
<p>The patient needs to know the importance of adhering to medication and following every prescribed medicine and activities by the nurse. The available online platforms with relevant information on these issues can be used for the education.</p>	<p>It is likely that the patient lacks adequate knowledge on what makes his health status poor. The knowledge he needs is available and can only be offered by the nurse who currently administers the home-based care. The education is a way of creating awareness and increasing the patient involvement in the self-care process.</p>

**Part IV: Ongoing Nursing Plan of Care**

**Collaboration**

**8. *What professional referrals (OT/PT, speech etc.) will be needed to advance the plan of care?***

The patient needs a therapeutic referral to help with the care plan. While the abdominal distension can be addressed medically, there is a high need for therapeutic intervention to increase the level of activity with the help of a professional. This ensures the intervention is supervised by a professional and is ascertained to be effective.

## **Planning Next Visit**

**9. *What does the nurse need to reinforce/communicate before leaving this visit to advance the plan of care and ensure patient safety in the home?***

The nurse needs to reinforce that the house should be kept clean and tidy and that the patient takes more of cooked foods than the takeout foods. This should ensure the house does not have any fall risks and that the patient will have maintained a good weight in the next visit.

**10. *What supplies may the patient need that the nurse can provide or order?***

Groceries are the main supplies the patient needs, to kick-start the journey to consuming healthy foods. The nurse can easily order these and keep a stock in the house.

## **Evaluation: Recommendations to Primary Care Provider**

**11. *Are there any laboratory tests that need to be ordered before the next home visit?***

The patient needs a basic metabolic panel test before the next visit to inform the nurse of the metabolic composition in the body.

**12. *Are there any changes to current medical orders (treatments/dosages of meds) that the nurse needs to recommend?***

The current medical orders can be upheld and wait for any changes during the next visit if there will be any health issues (Ineffective medicines) with the current medication

**13. *Are there any new medications, supportive assistance, or alterations in the living arrangements that the nurse needs to recommend to address a current/potential problem?***

The current living arrangement needs to be modified. The patient needs someone to stay with to kill the isolation and keep the patient engaged most of the times.

**Summarize this home visit by providing the following SBAR report to the primary care provider:**

Situation: Patient with possible heart failure, situation stable
<p><b>Name/age:</b> Frank Smith, 75 years</p> <p><b>BRIEF summary of primary problem:</b> History of chronic heart condition and obesity.</p> <p><b>Hospital Discharge date/Home Care Visit #1</b></p>
Background:
<p><b>Primary problem/diagnosis:</b> Patient suffers chronic heart condition and overweight issues.</p> <p><b>RELEVANT past medical history:</b> patient suffers type II diabetes and major heart conditions including heart failure risks.</p> <p><b>RELEVANT background data:</b> patient lives in isolation and has poor lifestyle</p>
Assessment:
<p><b>Most recent vital signs:</b> Blood pressure 140/90</p> <p><b>RELEVANT body system nursing assessment data:</b> Heart rate and rhythm needs to be keenly monitored</p> <p><b>Nursing Interventions &amp; Outcomes:</b> Patient needs to adjust lifestyle and maintain healthy diets and behaviors</p> <p><b>Patient response:</b> patient response is positive, willing to learn and cooperative</p> <p><b>INTERPRETATION of current clinical status (stable/unstable/worsening):</b> stable</p>
Recommendation:
<p><b>Suggestions to advance the plan of care; Visit Frequency/Plans for next visit:</b></p> <p>Patient needs education on the medication and self-care management, and reforms in the current living situation.</p>

## References

- Houlden, R. L., Yen, H. H., & Mirrahimi, A. (2017). The Lifestyle History: A Neglected But Essential Component of the Medical History. *American journal of lifestyle medicine*, *12*(5), 404–411. <https://doi.org/10.1177/1559827617703045>
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