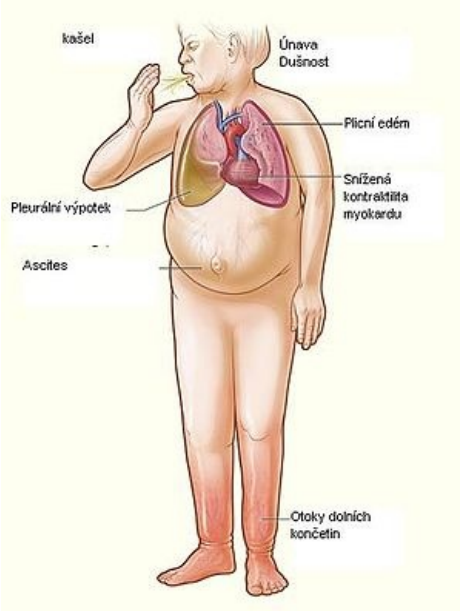
Nursing care of a patient with heart failure/HF (nurse)

Template:SŠ

Nursing care

- Impairment of tissue blood flow and increase in the volume of body fluids as a result of a decrease in srd. excretion and retention of sodium.
- Risk of impaired gas exchange in the lungs as a result of fluid accumulation in the lungs.
- Swelling of the limbs due to reduced mobility and less blood supply to peripheral tissues.
- Reduction of physical performance and limitation of self-care.
- Anxiety, fear, confusion caused by the symptoms of the disease.
- Sleep disorders due to nocturia.



Symptoms of heart failure

Goals of nursing care

- Monitor the patient's condition and his physiological functions and prevent the deterioration of the condition and the emergence of complications.
- Improve heart function by correct administration of prescribed drugs.
- A suitable position to ensure comfort and improvement of respiratory functions.
- Calm the patient, induce a feeling of security and trust and peaceful sleep.
- Ensure hygienic care, defecation care and nutrition.

Nursing Care Plan

- Patient admitted to internment, ICU, ARO according to status.
- The patient is placed in a high Fowler's position or orthoptic.
    - Room with O_2, chair for cardiac patients, near toilet, bell.
- Peripheral cannula for drug administration, the effect of diuretic and cardiotonic is monitored.
- Blood sampling according to the doctor's office, EKG, pulse, BP, d, O_2, we will teach you about coughing.

We are following

- VITAL SIGNS – BP, P, D, consciousness, EKG, cough and expectoration, character of cough and appearance of sputum.
- EMPTYING of urine and faeces, diuresis in 24 hours, FLUID BALANCE.
- STATUS OF BLOOD PERIP. tissue, skin color – pallor, cyanosis, skin temperature.
- LAB VALUES. RESULT – minerals, coagulation, astrup.
- WEIGHT – indicator of changes in the volume of body fluids.
- SWELLING - sight, palpation, the circumference of the abdomen and ankles with a tape measure.
- MENTAL STATUS – loss of appetite, moodiness, fatigue, pain, insomnia.
- DEGREE OF SELF-SUFFICIENCE – prevention of bedsores, bedsores, less effort, hyg. care, care for swollen limbs.
- DIET - restriction of salt (salt retains fluids in the body).
- EDUCATION PAC. – no smoking, healthy lifestyle, less salt, eat more often and less, do not exert yourself.

Developed nursing diagnoses

Shortness of breath due to asthma cardiale (pulmonary edema)

- **Aim:** To improve gas exchange in the breath. travel, eliminate shortness of breath, improve breathing.
- **Plan:**
    - Serve O_2.
    - Monitor physiological functions.
    - Orthoptic position for better breathing.
    - Watch for wheezing and wheezing during expiration, expectoration with pink sputum admixture.

Pain induced as a result of cardiac muscle ischemia

- **Goal:** To relieve or eliminate pain.
- **Plan:**
  - Administer analgesics according to the doctor.
  - Monitor pain and evaluate it verbally or non-verbally, record in documentation.
  - Relief position.

Fear, anxiety

- **Goal:** Alleviate fear, eliminate anxiety.
- **Plan:**
  - Cooperate with pac.
  - Explain the performed procedures, mediate consultations with the doctor.
  - Support the patient in formulating what he is afraid of.
  - Enough time to talk.

Links

References

- ŠAFRÁNKOVÁ, Alena – NEJEDLÁ, Marie. *Interní ošetřovatelství I.* 1. edition. Grada, 2006. 280 pp. ISBN 80-247-1148-6.

Kategorie:Zdravotní sestra