[redacted] insert your name here

Clinical Judgement Plan

West Coast University

[redacted] insert instructor name here

[redacted] insert date here

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Patient Information

Patient Initials: J.T.

Admission Date: 02/01/2026

Chief Complaint: Worsening shortness of breath

Age & Gender: 58 y/o Male

Admission Weight: 95.3 kg

Allergies: NKDA

Code Status: Full Code

Living Will/ DPOA: None

History of Present Illness (HPI)

J.T. is a 58-year-old Hispanic male who presented to the emergency department with progressively worsening shortness of breath over these past two weeks. He reports difficulty breathing requiring three pillows to sleep due to orthopnea and waking up at night gasping for air consistent with paroxysmal nocturnal dyspnea. He also reports bilateral lower extremity swelling and an unintentional 10 pound weight gain over the past month despite a decreased appetite. Patient denies chest pain but reports palpitations and dizziness with short distance ambulation. He states that his urine output has decreased over the last three days. He also missed his cardiology follow up appointments due to lack of transportation.

Admitting Diagnosis & Pathophysiology

Pt was admitted to the emergency department for Acute Decompensated Heart Failure (ADHF).

ADHF occurs when the heart suddenly becomes unable to pump enough blood to meet the body's needs (Yale Medicine, 2024). In this condition the weakened heart is unable to effectively move blood forward. This causes a decrease in cardiac output and fluid retention throughout the body. In this patient a reduced left ventricular ejection fraction allows blood to back up into the lungs. It resulted in pulmonary congestion and impaired gas exchange. This explains the patient's shortness of breath and low oxygen levels. Fluid accumulation in the peripheral tissues leads to bilateral lower extremity edema and rapid weight gain. Additionally, "Low output symptoms are caused by the inability of the heart to generate enough cardiac output" (Healthwise Staff, 2024). The reduced blood flow leads to decreased urine output.

Medical History & Pathophysiology

Pt has a medical history of heart failure (EF 30%), hypertension, type 2 diabetes mellitus, hyperlipidemia, and tobacco use.

Heart Failure (EF 30%) - Heart failure with a reduced ejection fraction means the heart is weak and can't pump blood effectively. An ejection fraction of 30% shows that the heart is not pushing enough blood forward for it function properly. This leads to decreased cardiac output and causes blood to back up into the lungs and tissues. "Less oxygen-rich blood is pumped out to the body" (American Heart Association, 2025). This results in shortness of breath, fatigue, and swelling. Patients with low ejection fraction is a high risk factor for acute heart failure exacerbations.

Hypertension - Hypertension causes the heart to work harder to be able to pump blood against the increased pressure in the blood vessels. "The extra work can make the heart muscle too stiff or too weak to properly pump blood" (Mayo Clinic, 2025). This extra workload does weaken the heart muscle and cause heart failure.

Type 2 Diabetes - Type 2 diabetes affects the heart and blood vessels by damaging them over time due to those high blood sugar levels. Diabetes increases the risk of heart disease and can make heart failure worse by affecting circulation and the heart function. "Diabetes is also tied to developing heart failure more quickly and at a younger age" (American Diabetes Association, 2024).

Hyperlipidemia - Hyperlipidemia is the presence of high cholesterol levels in the blood. High cholesterol can cause plaque buildup in the arteries which does decrease the blood flow to the heart. "Treating hyperlipidemia and obesity is critical for maintaining a healthy heart" (Brigham, 2024).

Tobacco use - Tobacco use damages blood vessels, increases blood pressure, and reduces the amount of oxygen delivered to the body. Smoking also increases the risk of heart disease and heart failure. Although the patient has stopped smoking the previous tobacco use has likely contributed to his long term heart and blood vessel damage. "Smoking is a leading preventable cause of morbidity and mortality from cardiovascular disease and a major contributor to all forms of cardiovascular disease, including HF" (JAAC, 2022).

Surgical History & Pathophysiology

J.T. has a history of percutaneous coronary intervention with stent placement performed about 18 months ago. "A stent is placed at the narrowed part to help keep the artery open" (Mayo Clinic, 2023). This procedure was completed to restore blood flow to a narrowed coronary artery caused by atherosclerotic plaque buildup. Although the stent improved coronary perfusion, the underlying cardiac disease and reduced myocardial function placed the patient at a continued risk for heart failure progression and acute decompensation.

Social History

The patient is a retired postal worker who lives at home with his wife and two adult children. He reports no current use of tobacco, alcohol, or illicit drugs. The patient has difficulty attending medical appointments due to transportation challenges. He is insured through Medicare with supplemental insurance coverage.

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Social Determinants of Health

Ethnicity: Hispanic
Occupation: Retired
Religion: Not specified
Family support: Wife and adult children
Insurance: Medicare with supplemental insurance

3 Psychosocial Considerations/Concerns
1. Transportation and Health Care Access:
The patient has difficulty attending cardiology appointments due to transportation barriers. The missed care and poor management of his heart failure increases risk for symptoms worsening and hospital readmission. Managing heart failure requires a team effort and is needed to improve health (American Heart Association, 2024).

2. Decreased Independence:
The patient experiences fatigue and shortness of breath which makes it difficult for him to complete daily tasks and participate in family activities. In a research study, "Most people noticed that they got fewer things done each day and that they sometimes became breathless and tired when they did too much" (HealthTalk, 2026). These physical limitations can lower his quality of life and increase stress related to feeling less independent.

3. Chronic Disease Burden and Stress:
The patient is managing several chronic conditions, including heart failure, diabetes, hypertension, and hyperlipidemia. This can all feel overwhelming. Managing multiple illnesses requires many medications and lifestyle changes which can increase stress and make it harder to stay consistent with treatment. The article states that, "Individuals with chronic physical health conditions, particularly those with more symptomatic or multiple chronic conditions, have elevated risks of experiencing psychological distress" (Adzrago et al., 2024).

Erikson's Developmental Stage Related to Patient (1) *List and discuss specific stage (based on objective assessment)

The patient is in Erikson's stage of generativity vs. stagnation, which is typical for middle adulthood. At this stage in life, people usually want to stay independent, feel useful, and continue supporting their family. "Stagnation involves feeling unproductive and uninvolved, leading to self-absorption, lack of growth, and feelings of emptiness" (Simply Psychology, 2025). Since J.T. is dealing with shortness of breath and fatigue from heart failure he may have trouble doing things he normally could. This can be found as frustrating and discouraging. Nursing care should focus on helping him stay as independent as possible, encouraging him to take part in his care, and supporting him as he adjusts to changes in his health.

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Teaching Assessment and Client Education

Learning Preference
The patient appears to benefit from clear verbal explanations and simple written instructions. Teaching should be done using plain and preferred language (CDC, 2024). The nurse and physician should provide repetition and teach back to confirm understanding.

Barriers to Learning and Specific Needs
The patient may have difficulty learning due to fatigue, shortness of breath, and feeling overwhelmed by managing multiple chronic conditions. Transportation barriers may also limit follow up education and reinforcement of teaching. Teaching should be provided in short sessions with opportunities for questions and clarification.

Client Education
Client education should focus on heart failure management, including the importance of taking medications as prescribed, monitoring daily weight, following a low sodium diet. He should recognize signs of worsening heart failure such as increased shortness of breath, swelling, sudden weight gain, and decreased urine output. “One strategy for preventing readmissions is to schedule an outpatient follow-up visit before discharge” (CDC, 2024). The patient must be educated on the importance of keeping up with his follow up appointments and when to seek medical attention to prevent complications and hospital readmission.

Interprofessional Consults and Multidisciplinary Plan

Cardiologist
A cardiology consult is needed to manage the patient’s acute decompensated heart failure, adjust cardiac medications, and monitor heart function. A cardiologist can also guide long term treatment to reduce the risk of future heart failure exacerbations. They have a major impact on a patient’s life to control symptoms and find the best solution for them (Cleveland Clinic, 2024).

Registered Dietitian
A registered dietitian should be consulted to provide education on a low sodium and heart healthy diet. Dietary guidance is important for J.T. to help manage his fluid retention, reduce edema, and support overall cardiac health. “Saturated fats and trans fats are not supportive to heart health” (Cleveland Clinic, 2024). A dietitian will coordinate the right meal plan that fits his needs.

Social Worker
A social worker should be involved to address transportation barriers that have interfered with the patient’s ability to attend follow up appointments. “Challenges related to lack of insurance, lack of a regular health care provider, costs, health literacy, and travel are just a few of the many barriers to implementing outpatient follow up visits effectively” (CDC, 2024). The social worker can assist with community resources, appointment coordination, and support services to improve access to care.

Physical Therapy
Physical therapy may be consulted to help improve the patient’s activity tolerance and strength while preventing deconditioning. Therapy can also provide guidance on safe activity levels given the patient’s fatigue and shortness of breath. Due to his heart failure, J.T. gets fatigue easily placing him at risk for weakness and decreased mobility. “Exercising helps improve the heart's pumping ability, decreases blood vessel stiffness and improves the function and energy capacity of skeletal muscle” (ANA, 2023).

Discharge Planning

Discharge planning for this patient should focus on preventing worsening heart failure and reducing the risk of hospital readmission. “Patients need education and guidance on self-monitoring of symptoms at home, medication compliance, daily weight monitoring, dietary sodium restriction to 2 to 3 g/day, and daily fluid restriction to 2 L/day” (Kaur & Gupta, 2023). The patient should be discharged with clear instructions on taking medications as prescribed, following a low-sodium diet, and monitoring daily weights at home. He should be instructed to weigh himself every morning and report weight gain of 2 to 3 pounds in one day or 5 pounds in one week. Education should also include recognizing warning signs such as increased shortness of breath, swelling in the legs, fatigue, dizziness, or decreased urine output. Follow up appointments with cardiology and primary care should be scheduled prior to discharge. Transportation needs should be addressed to ensure he can attend these visits. Family members should also be included in discharge teaching to provide support with medication management and symptom monitoring at home.

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Lab Tests with Values
(Include normal ranges, dates, and rationales of abnormal results)

Lab Tests or Diagnostic Tests	Normal Ranges	Admission Lab Values	Current Lab Values	Explain Abnormal Results R/T Your Patient (USE additional pages at the end of template WHEN NEEDED)
BNP	<100 pg/mL	2,350 pg/mL	2,350 pg/mL	This BNP level is severely elevated and indicates the heart is under stress and fluid overload. “Higher-than-normal levels of BNP can be a sign that your heart isn’t pumping enough blood through your body” (Cleveland Clinic, 2025).
Troponin	<0.01 ng/mL	0.03 ng/mL	0.03 ng/mL	This troponin level is not significantly elevated and does not suggest an acute myocardial infarction. “The more damage there is to the heart, the greater the amount of troponin T and I there will be in the blood” (UF Health, 2023).
CMP	**Na** 135-145 mEq/L **BUN** 7-20 mg/dL **Cr** 0.6-1.2 mg/dL	**Na** 130 mEq/L **BUN** 30 mg/dL **Cr** 1.8 mg/dL	**Na** 130 mEq/L **BUN** 30 mg/dL **Cr** 1.8 mg/dL	The low sodium level is related to fluid overload in heart failure. An elevated BUN and Cr ratio suggests greater renal hypoperfusion and fluid overload which contribute to worse outcomes in heart failure patients (Frontier, 2025).
CBC	**WBC** 4,000-11,000mm³ **Hgb** 13.8-17.2 g/dL (male) **Hct** 40-54% **Platelets** 150,000-450,000/mm³	**WBC** 8,000/mm³ **Hgb** 14.0 g/dL **Hct** 42% **Platelets** 220,000/mm³	**WBC** 8,000/mm³ **Hgb** 14.0 g/dL **Hct** 42% **Platelets** 220,000/mm³	CBC is within normal range.
Lipid Panel	**Total Cholesterol** <200 mg/dL **LDL** <100 mg/dL **HDL** >40 mg/dL **Triglycerides** <150 mg/dL	**Total Cholesterol** 220 mg/dL **LDL** 140 mg/dL **HDL** 40 mg/dL **Triglycerides** 180 mg/dL	**Total Cholesterol** 220 mg/dL **LDL** 140 mg/dL **HDL** 40 mg/dL **Triglycerides** 180 mg/dL	The lipid panel shows elevated total cholesterol, LDL, and triglycerides indicating poorly controlled dyslipidemia. “A high triglyceride level combined with high LDL cholesterol or low HDL cholesterol is linked with fatty buildups within the artery walls” (Heart.org, 2024). Abnormal lipid levels increase cardiovascular risk and contribute to the progression of heart disease.
ABG	**pH:** 7.35-7.45 **pCO_2:** 35-45 mmHg **HCO_3:** 22-26 mEq/L	**pH** 7.33 **pCO2** 50 mmHg **HCO3** 24 mEq/L	**pH** 7.33 **pCO2** 50 mmHg **HCO3** 24 mEq/L	The ABG results show respiratory acidosis with a low pH and elevated carbon dioxide level. “Respiratory acidosis is when your lungs can’t remove all the carbon dioxide that your body produces, so your blood pH is lower (more acidic) than normal” (Cleveland Clinic, 2023). This finding in this patient is consistent with impaired gas exchange due to pulmonary congestion in acute heart failure.
Coagulation Profile (INR,aPTT)	**INR**: 0.9-1.1, **aPTT**: 25-35 seconds	**INR** 1.2, **aPTT** 30 seconds	**INR** 1.2, **aPTT** 30 seconds	Coagulation Profile of INR and aPTT is within normal range.
TSH	0.4-4.0 µIU/mL	2.2 µIU/mL	2.2 µIU/mL	TSH is within normal range.
Blood Glucose	70-110 mg/dL (fasting)	180 mg/dL	180 mg/dL	This elevated blood glucose level indicates hyperglycemia consistent with poorly controlled diabetes. "Diabetes contributes to disease progression in HF and is associated with worse prognosis” (DMJ, 2021).

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Diagnostics

(3) Relevant Diagnostic Procedures with Results

EKG
Results: Sinus tachycardia with premature ventricular contractions (PVCs)
Normal Reading: A normal EKG demonstrates normal sinus rhythm with a heart rate between 60–100 beats per minute and no abnormal rhythms. “A normal EKG should show a regular series of waves that repeat. There’s a small bump (P wave), a spike (QRS complex) and then another small bump (T wave)” (Cleveland Clinic, 2025).
Reasoning: An EKG is used to assess heart rhythm and identify arrhythmias or ischemic changes that may worsen heart failure symptoms. “An EKG reads that signal and tracks its impact on your heart as it contracts and relaxes with each heartbeat” (Cleveland Clinic, 2025).

Chest X-Ray
Results: Cardiomegaly with pulmonary congestion noted.
Normal Reading: A normal chest X-ray shows clear lung fields and chest cavity with no visible nodules, tumors, or masses (Cleveland Clinic, 2023). The results should come back as a normal sized heart without signs of fluid overload.
Reasoning: A chest X-ray provides information about heart size and lung status and can identify pulmonary edema related to heart failure. A chest X-ray can reveal the condition of the lungs, size and shape, and presence of fluid (Mayo Clinic, 2024).

2D Echocardiogram
Results: Left ventricular ejection fraction of approximately 30%.
Normal Reading: A normal echocardiogram reveals normal heart valves, chambers, and heart wall movement. A normal ejection fraction ranges from 55–70% with normal ventricular function (Heart.org, 2025).
Reasoning: “This test is done to evaluate the valves and chambers of your heart and the sac around your heart (pericardium) from the outside of your body” (UCSF Health, 2023).

CT Chest
Results: No evidence of pulmonary embolism.
Normal Reading: A normal CT chest shows clear lung fields and normal pulmonary vasculature without emboli.
Reasoning: “A CT scan of the chest can help find problems such as infection, lung cancer, blocked blood flow in the lung (pulmonary embolism), and other lung problems” (Kaiser, 2025).

Cardiac MRI
Results: Awaiting results.
Normal Reading: A normal cardiac MRI demonstrates normal myocardial structure and contractility.
Reasoning: Cardiac MRI is used to look at heart structure and function, blood flowing through blood vessels, and how much blood the left ventricle can pump to the body (Heart.org, 2025).

Arterial Blood Gas
Results: pH 7.33, pCO_2 50 mmHg, HCO_3 24 mEq/L.
Normal Reading: Normal ABG values include a pH of 7.35–7.45, pCO_2 of 35–45 mmHg, and HCO_3 of 22-26 mEq/L.
Reasoning: An ABG test determines the oxygen and carbon dioxide levels in the blood to access lung function and gas exchange (Hartford, 2025).

Urinalysis
Results: Proteinuria with specific gravity of 1.010.
Normal Reading: Normal urinalysis shows no protein and normal urine concentration.
Reasoning: A urinalysis checks for proteins, blood cells, other substances. It is used to look for kidney or liver disease, infection, diabetes, and more. “Proteinuria is a mediating factor of atherosclerotic cardiovascular disease and heart failure, which increases the risk of SCA” (AHA Journals, 2025).

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Medication Name	Dose	Route	Frequency	Purpose of Medication for Your Patient	Mechanism of Action	Side Effects/Adverse Reactions	Nursing Considerations
Furosemide	20-40 mg	IV or PO	Daily or twice daily IV or PO	To reduce fluid overload and improve shortness of breath and edema related to acute decompensated heart failure.	Loop diuretic that inhibits sodium and water reabsorption in the kidneys, decreasing circulating volume.	Hypotension, dehydration, hypokalemia, hyponatremia, dizziness, orthostatic hypotension, increased urination, hearing changes with high doses.	Teach the patient to change positions slowly to prevent dizziness and falls. Instruct to monitor daily weight and report weight gain or loss greater than 2–3 lbs in one day. Teach the patient to report muscle cramps, weakness, or dizziness, which may indicate electrolyte imbalance (Jones & Bartlett Learning, 2025).
Bumetanide	0.5–1 mg	IV or PO	Daily	Used to treat severe fluid retention when additional diuresis is needed.	Loop diuretic that promotes sodium and water excretion by the kidneys.	Dehydration, hypotension, electrolyte imbalances (low potassium, sodium), dizziness, increased urination.	Educate the patient to take the medication earlier in the day to reduce nighttime urination. Teach the patient to report dizziness, muscle weakness, or signs of dehydration such as dry mouth or decreased urine output (Jones & Bartlett Learning, 2025).

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Medication Name	Dose	Route	Frequency	Purpose of Medication for Your Patient	Mechanism of Action	Side Effects/Adverse Reactions	Nursing Considerations
Lisinopril	5–20 mg	PO	Daily	Improves cardiac output and lowers blood pressure in heart failure.	ACE inhibitor that blocks angiotensin II, causing vasodilation and decreased fluid retention.	Hypotension, dry cough, dizziness, hyperkalemia, renal impairment, angioedema	Teach the patient to avoid potassium supplements and salt substitutes. Instruct the patient to report facial swelling, difficulty breathing, or persistent cough. Advise changing positions slowly to prevent dizziness (Jones & Bartlett Learning, 2025).
Enalapril	2.5–10 mg	PO	Daily	Reduces cardiac workload and improves heart failure symptoms.	ACE inhibitor that decreases vasoconstriction and aldosterone secretion	Hypotension, cough, dizziness, hyperkalemia, renal dysfunction	Teach the patient to monitor blood pressure at home if instructed. Instruct to report dizziness, swelling of the face or lips, or signs of kidney problems such as decreased urine output (Jones & Bartlett Learning, 2025).

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Medication Name	Dose	Route	Frequency	Purpose of Medication for Your Patient	Mechanism of Action	Side Effects/Adverse Reactions	Nursing Considerations
Carvedilol	3.125–25 mg	PO	Twice daily	Improves heart function and decreases mortality in heart failure.	Beta-blocker that decreases heart rate and myocardial oxygen demand.	Bradycardia, hypotension, fatigue, dizziness, weight gain, worsening heart failure symptoms initially.	Teach the patient to check heart rate before taking the medication and to report heart rate below 60 bpm. Educate that fatigue may occur initially and not to stop the medication abruptly without provider guidance (Jones & Bartlett Learning, 2025).
Metoprolol	25–100 mg	PO	Daily	Controls heart rate and reduces cardiac workload.	Beta-1 selective blocker that slows heart rate and decreases blood pressure.	Bradycardia, hypotension, fatigue, dizziness, shortness of breath, masking of hypoglycemia symptoms.	Teach the patient to monitor heart rate and blood pressure. Educate diabetic patients that signs of low blood sugar may be masked. Instruct not to stop medication suddenly (Jones & Bartlett Learning, 2025).
Spironolactone	12.5–25 mg	PO	Daily	Reduces fluid retention while conserving potassium in heart failure.	Aldosterone antagonist that increases sodium excretion and potassium retention.	Hyperkalemia, dizziness, dehydration, gynecomastia, menstrual irregularities.	Teach the patient to avoid potassium-rich foods and supplements. Instruct to report muscle weakness, irregular heartbeat, or decreased urine output (Jones & Bartlett Learning, 2025).

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Medication Name	Dose	Route	Frequency	Purpose of Medication for Your Patient	Mechanism of Action	Side Effects/Adverse Reactions	Nursing Considerations
Digoxin	0.125–0.25 mg	PO	Daily	Improves cardiac contractility and controls heart rate.	Increases myocardial contractility and slows AV conduction.	Bradycardia, nausea, vomiting, anorexia, visual disturbances (yellow/green halos), digoxin toxicity.	Teach the patient to take their pulse before taking the medication and to hold the dose if heart rate is below 60 bpm. Instruct to report nausea, vision changes, or irregular heartbeat immediately (Jones & Bartlett Learning, 2025).
Aspirin	81–325 mg	PO	Daily	Prevents platelet aggregation and reduces cardiovascular risk.	Inhibits platelet aggregation by blocking thromboxane A2.	GI irritation, nausea, bleeding, bruising, tinnitus with high doses.	Teach the patient to take aspirin with food to reduce stomach irritation. Instruct to report black stools, bleeding gums, or unusual bruising (Jones & Bartlett Learning, 2025).
Warfarin	Individualized	PO	Daily	Prevents thromboembolic complications.	Vitamin K antagonist that inhibits clotting factor synthesis.	Bleeding, bruising, hematuria, GI bleeding, prolonged clotting time.	Teach the patient to maintain consistent vitamin K intake and avoid activities that increase bleeding risk. Instruct to report bleeding, bruising, or dark stools and to keep regular INR lab appointments (Jones & Bartlett Learning, 2025).

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Medication Name	Dose	Route	Frequency	Purpose of Medication for Your Patient	Mechanism of Action	Side Effects/Adverse Reactions	Nursing Considerations
Nitroglycerin	0.4 mg	Sublingual	PRN chest pain	Relieves chest pain by improving coronary blood flow.	Vasodilator that reduces preload and myocardial oxygen demand.	Headache, hypotension, dizziness, flushing, reflex tachycardia.	Teach the patient to sit or lie down before taking nitroglycerin. Instruct to take up to three doses 5 minutes apart and seek emergency care if chest pain persists (Jones & Bartlett Learning, 2025).
Metformin	500–1000 mg	PO	Once or twice daily	Controls blood glucose levels in type 2 diabetes.	Decreases hepatic glucose production and improves insulin sensitivity.	GI upset (nausea, diarrhea), abdominal discomfort, vitamin B12 deficiency, lactic acidosis (rare).	Teach the patient to take medication with meals to reduce GI upset. Instruct to report muscle pain, weakness, or unusual fatigue and to hold medication before contrast studies as directed (Jones & Bartlett Learning, 2025).

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Physical Assessment/Review of Systems

Vital Signs/Height/Weight (4)

Temp: 98.9 F (oral)
HR: 118 bpm
BP: 90/58 mmHg
RR: 24 breaths/min
SpO2: 92% on 2L nasal cannula
Pain: 0/10
Height: 177.8 cm
Weight: 95.3 kg

Neurological (5)

Alert and oriented ×4 (person, place, time, situation)
Speech clear and appropriate
Reports dizziness with activity
No focal neurological deficits noted
Follows commands appropriately

Cardiovascular (6)

Tachycardic with heart rate 118 bpm
Blood pressure 90/58 mmHg, hypotensive
Peripheral pulses palpable but weak
+2 bilateral lower extremity edema
Capillary refill delayed
History of heart failure with reduced ejection fraction

Respiratory (7)

Respiratory rate 24 breaths per minute
Shortness of breath noted at rest and with minimal exertion
Oxygen saturation 92% on 2L nasal cannula
Cough present, nonproductive
Difficulty lying flat (orthopnea)

Hydration/Nutrition (8) and Gastrointestinal (GI) (9)

Poor appetite reported
Fluid retention noted with recent weight gain
Abdomen soft and non-tender
Bowel sounds present in all four quadrants
Denies nausea, vomiting, diarrhea, constipation, or abdominal pain
Last bowel movement today, normal consistency

Genitourinary (GU) (10)

Decreased urine output reported
Urine clear yellow
No dysuria or hematuria or urgency
Findings consistent with decreased renal perfusion related to heart failure

Musculoskeletal and Activity (11)

Generalized weakness noted
Decreased activity tolerance
Requires rest with minimal exertion
Limited endurance due to fatigue and shortness of breath
Lower extremity swelling attributed to fluid accumulation, not musculoskeletal cause
Denies joint pain, muscle cramps, or recent injuries

Integumentary (12)

Skin cool and pale
Bilateral lower extremity edema present
Occasional skin tightness but no rashes, wounds, or ulcers
Poor skin turgor noted

Hormone Regulation/ Reproduction/ Endocrine (13)

History of type 2 diabetes mellitus
Elevated blood glucose levels noted
No goiter or thyroid enlargement observed

HEENT

Head: Has normal hair distribution. No infestations, bumps, or lesions.
Ears: Bilaterally symmetrical, no tenderness or drainage.
Face: No facial drooping or tenderness. Skin color is appropriate to ethnicity.
Eyes: Pupils are equal, round, reactive to light, and accommodating. No extraocular eye movements. No redness.
Nose: Both nares are patent and no drainage noted.
Mouth/Gums: Lips not cracked, no bleeding gums, no swollen tongue, no dentures, no foul odor, denies difficulty swallowing, gums are pink and moist.
Neck: No swollen lymph nodes, no JVD, no goiter.

IV Lines/Drains/Tubes

Oxygen via nasal cannula at 2L
No drains or tubes present

Psychosocial (14)

Denies depression or suicidal ideation

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Observation	Interpreting		Responding
Assessment	Analysis	Planning	Implement

Recognize Cues

1. Worsening shortness of breath over two weeks
2. Requires three pillows to sleep (orthopnea)
3. Awakens at night gasping for air (paroxysmal nocturnal dyspnea)
4. Bilateral lower extremity swelling to mid-shin
5. Unintentional 10-lb weight gain in one month
6. Decreased appetite with early satiety
7. Fatigue and decreased exercise tolerance
8. Palpitations and awareness of irregular heartbeat
9. Dizziness and lightheadedness with short distances
10. Decreased urine output over three days
11. Missed cardiology appointments due to lack of transportation
12. Heart rate 118 bpm
13. Blood pressure 90/58 mmHg
14. Respiratory rate 24 breaths/min
15. Oxygen saturation 92% on 2L nasal cannula
16. BNP 2,350 pg/mL
17. Left ventricular ejection fraction ~30%
18. Pulmonary congestion on chest X-ray
19. Sodium 130 mEq/L
20. Elevated BUN and creatinine

Analyze Cues

Cardiovascular
- Reduced ejection fraction (~30%)
- Tachycardia (HR 118 bpm)
- Hypotension (BP 90/58 mmHg)
- Elevated BNP (2,350 pg/mL)
- Palpitations and irregular heartbeat
- Bilateral lower extremity edema

Respiratory
- Worsening dyspnea with minimal activity
- Orthopnea (three pillows)
- Paroxysmal nocturnal dyspnea
- Tachypnea (RR 24 breaths/min)
- Oxygen saturation 92% on 2L nasal cannula
- Pulmonary congestion on chest X-ray

Renal
- Decreased urine output
- Elevated BUN and creatinine
- Hyponatremia (Na 130 mEq/L)

Neurological
- Dizziness and lightheadedness with exertion
- Fatigue and decreased activity tolerance

Metabolic / Fluid Balance
- 10-lb weight gain in one month
- Early satiety and poor appetite
- Peripheral fluid retention

Social / Access to Care
- Missed cardiology follow-up appointments
- Transportation barriers impacting care

Prioritize Hypotheses

1. Decreased Cardiac Output

J.T. has a reduced left ventricular ejection fraction (~30%), hypotension, tachycardia, elevated BNP, fatigue, and decreased urine output, all of which indicate impaired cardiac pumping ability. This is the highest priority because decreased cardiac output affects circulation to vital organs. According to the American Heart Association, heart failure occurs when "the heart can't pump enough blood to meet the body's needs," which can lead to poor organ perfusion and clinical deterioration (American Heart Association, 2024).

Framework: ABCs (Circulation)

2. Impaired Gas Exchange

Fluid accumulation related to heart failure has caused worsening dyspnea, orthopnea, paroxysmal nocturnal dyspnea, tachypnea, and decreased oxygen saturation. These findings show impaired oxygen exchange and require prompt intervention. Heart failure can cause fluid buildup in the lungs, which "makes it difficult to breathe" and interferes with normal gas exchange (Mayo Clinic, 2024).

Framework: ABCs (Breathing)

3. Excess Fluid Volume

J.T. demonstrates excess fluid volume as evidenced by bilateral lower extremity edema, pulmonary congestion, hyponatremia, and a 10-lb weight gain in one month. Fluid overload increases cardiac workload and worsens respiratory symptoms. Heart failure often causes "fluid buildup that leads to swelling, weight gain, and shortness of breath" (Cleveland Clinic, 2023).

Framework: Safety

4. Decreased Renal Perfusion

Reduced cardiac output has led to decreased blood flow to the kidneys resulting in decreased urine output and elevated BUN and creatinine levels. If untreated this can lead to worsening kidney function. The National Kidney Foundation notes that in heart failure reduced blood flow can "limit how well the kidneys work and reduce urine output" (National Kidney Foundation, 2023).

Framework: Maslow's hierarchy of needs

Generate Solutions

1. Decreased Cardiac Output

By the end of 12 hours, the patient will demonstrate improved cardiac output as evidenced by improved blood pressure, heart rate trending toward baseline, increased urine output, and decreased dizziness with activity.

-Monitor vital signs (heart rate and blood pressure) every 2–4 hours to assess cardiac function and perfusion.
-Monitor urine output closely and report output less than 30 mL/hr as an indicator of decreased renal perfusion.
-Position the patient in semi-Fowler's to reduce cardiac workload and improve circulation.
-Assess for signs of decreased perfusion, including dizziness, fatigue, cool extremities, and delayed capillary refill (Mayo Clinic, 2024).

2. Impaired Gas Exchange

By the end of 12 hours, the patient will demonstrate improved oxygenation as evidenced by oxygen saturation of at least 94%, decreased shortness of breath at rest, improved respiratory rate, and ability to rest with fewer pillows without respiratory distress.

-Monitor oxygen saturation and respiratory rate every 2–4 hours to assess oxygenation status.
-Position the patient in high Fowler's position to promote lung expansion and ease breathing.
-Encourage rest periods and controlled breathing to reduce oxygen demand and work of breathing.
-Monitor for worsening respiratory symptoms such as increased shortness of breath, tachypnea, or decreased oxygen saturation, which may indicate worsening heart failure (Mayo Clinic, 2024).

3. Excess Fluid Volume

By the end of 12 hours, the patient will demonstrate improved fluid balance as evidenced by decreased bilateral lower extremity edema, no further weight gain, improved breathing comfort, and balanced intake and output.

-Monitor daily weight and compare trends to assess changes in fluid status.
-Assess and document the presence and severity of peripheral edema each shift.
-Monitor intake and output accurately to evaluate effectiveness of fluid management.
-Educate the patient on the importance of following fluid and sodium restrictions to reduce fluid retention and prevent worsening heart failure (Mayo Clinic, 2024).

4. Decreased Renal Perfusion

By the end of 12 hours, the patient will demonstrate improved renal perfusion as evidenced by urine output of at least 30 mL/hr, stable kidney laboratory values, improved blood pressure, and no worsening signs of fluid retention.

-Monitor urine output closely and report output less than 30 mL/hr to assess kidney perfusion.
-Monitor BUN, creatinine, and electrolyte levels as ordered to evaluate renal function.
-Monitor blood pressure regularly and report hypotension, as low blood pressure can further reduce kidney perfusion.
-Educate the patient to report decreased urine output, sudden weight gain, or worsening swelling, which may indicate declining kidney function (Mayo Clinic, 2024).

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Take Action

1. Monitor heart rate and blood pressure every 2–4 hours to evaluate cardiac function and tissue perfusion.
2. Monitor urine output hourly and report output less than 30 mL/hr to assess organ perfusion.
3. Position the patient in semi-Fowler's position to reduce cardiac workload and improve circulation.
4. Assess for signs of decreased perfusion, including dizziness, fatigue, cool extremities, and delayed capillary refill.
5. Monitor oxygen saturation and respiratory rate every 2–4 hours to assess oxygenation status.
6. Position the patient in high Fowler's position to promote lung expansion and ease breathing.
7. Encourage rest periods and controlled breathing to reduce oxygen demand.
8. Monitor for worsening respiratory symptoms such as increased shortness of breath or decreased oxygen saturation.
9. Monitor daily weight at the same time each day to track fluid retention.
10. Assess and document bilateral lower extremity edema each shift.
11. Monitor intake and output accurately to evaluate fluid balance.
12. Reinforce fluid and sodium restriction education to prevent further fluid accumulation.
13. Monitor urine output closely and report decreased output as an indicator of impaired renal perfusion.
14. Monitor renal laboratory values, including BUN, creatinine, and electrolytes, as ordered.
15. Monitor blood pressure regularly and report hypotension promptly to prevent further renal compromise.
16. Educate the patient to report decreased urine output, sudden weight gain, or worsening swelling. (MayoClinic, 2024).

Evaluate

Evaluation

1. By the end of 12 hours, the patient demonstrated improved cardiac output as evidenced by heart rate decreasing from 118 bpm to 92 bpm, systolic blood pressure increasing from 90 mmHg to 110 mmHg, urine output increasing to greater than 35 mL/hr, and the patient reporting decreased dizziness with ambulation.

2. By the end of 12 hours, the patient maintained improved oxygenation as evidenced by oxygen saturation increasing from 92% on 2L nasal cannula to 95–96% on room air, respiratory rate decreasing to 18 breaths per minute, and the patient denying shortness of breath at rest or with minimal activity.

3. By the end of 12 hours, the patient demonstrated improved fluid balance as evidenced by no additional weight gain, decreased bilateral lower extremity edema from +2 to +1, improved breathing comfort, and balanced intake and output documentation.

4. By the end of 12 hours, the patient demonstrated improved renal perfusion as evidenced by urine output increasing to at least 40 mL/hr, stabilization of BUN and creatinine levels, improved blood pressure supporting kidney perfusion, and no worsening signs of fluid retention.

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Reference Page

Adzrago, D., Eghan, F., & Jin, Y. (2024). *Multiple chronic conditions and psychological distress among adults*. *Preventing Chronic Disease*, 21, Article 240132. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11739432/

American Diabetes Association. (2024). *How diabetes affects heart failure*. https://diabetes.org/health-wellness/diabetes-and-your-heart/diabetes-affects-heart-failure

American Heart Association. (2023). *Exercise therapy may improve quality of life for people with common type of heart failure*. https://www.heart.org/en/news/2023/03/21/exercise-therapy-may-improve-quality-of-life-for-people-with-common-type-of-heart-failure

American Heart Association. (2025). *Ejection fraction (heart failure measurement)*. https://www.heart.org/en/health-topics/heart-failure/diagnosing-heart-failure/ejection-fraction-heart-failure-measurement

American Heart Association. (2024). *HDL (good), LDL (bad) cholesterol and triglycerides*. https://www.heart.org/en/health-topics/cholesterol/hdl-good-ldl-bad-cholesterol-and-triglycerides

American Heart Association. (2025). *Treatment options for heart failure*. https://www.heart.org/en/health-topics/heart-failure/treatment-options-for-heart-failure

American Heart Association. (2025). *What is heart failure?* https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure

American Heart Association Journals. (2024). *Journal of the American Heart Association*. https://www.ahajournals.org/doi/10.1161/JAHA.124.036077

Brigham and Women's Hospital. (2024). *Hyperlipidemia (high blood cholesterol)*. https://www.brighamandwomens.org/heart-and-vascular-center/diseases-and-conditions/hyperlipidemia-high-blood-cholesterol

Centers for Disease Control and Prevention. (2024). *Health literacy*. https://www.cdc.gov/health-literacy/php/about/

Centers for Disease Control and Prevention. (2024). *Preventing chronic disease*. https://www.cdc.gov/pcd/issues/2024/24_0138.htm

Cleveland Clinic. (2025). *B-type natriuretic peptide (BNP)*. https://my.clevelandclinic.org/health/diagnostics/22629-b-type-natriuretic-peptide

Cleveland Clinic. (2024). *Cardiologist*. https://my.clevelandclinic.org/health/articles/21983-cardiologist

Cleveland Clinic. (2023). *Chest X-ray*. https://my.clevelandclinic.org/health/diagnostics/10228-chest-x-ray

Cleveland Clinic. (2025). *Electrocardiogram (EKG)*. https://my.clevelandclinic.org/health/diagnostics/16953-electrocardiogram-ekg

Clinical Judgement Plan

Instructor: Professor Iwuoma
DATE Care Provided and UNIT: 02/01/2026

Cleveland Clinic. (2023). *Respiratory acidosis*. https://my.clevelandclinic.org/health/diseases/24834-respiratory-acidosis

Cleveland Clinic. (2024). *Can a registered dietitian nutritionist help your heart health?* https://my.clevelandclinic.org/podcasts/love-your-heart/can-a-registered-dietitian-nutritionist-help-your-heart-health

Frontiers in Cardiovascular Medicine. (2025). *Advances in heart failure management*. https://www.frontiersin.org/journals/cardiovascular-medicine/articles/10.3389/fcvm.2025.1510317/full

Hartford Hospital. (2025). *Arterial blood gas (ABG) test*. https://hartfordhospital.org/health-wellness/health-resources/health-library/detail?id=tw9890&lang=en-us

HealthTalk. (n.d.). *Home life and everyday routines with heart failure*. https://healthtalk.org/experiences/heart-failure/home-life-and-everyday-routines/

Healthwise S*taff. (2024, July 31). Heart failure: Compensation by the heart and body*. MyHealth Alberta, Government of Alberta. https://myhealth.alberta.ca/Health/pages/conditions.aspx?hwid=aa86963

JACC: Heart Failure. (2022). *Journal of the American College of Cardiology: Heart Failure*. https://www.jacc.org/doi/10.1016/j.jchf.2022.07.006

Kaiser Permanente. (2024). *CT scan of the chest*. https://healthy.kaiserpermanente.org/health-wellness/health-encyclopedia/he.ct-scan-of-the-chest-about-this-test.ug6606

Kaur, R., & Gupta, R. (2023). *Heart failure*. In StatPearls. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK574497/

Mayo Clinic. (2024). *Chest X-rays*. https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494

Mayo Clinic. (2023). *Coronary angioplasty*. https://www.mayoclinic.org/tests-procedures/coronary-angioplasty/about/pac-20384761

Mayo Clinic. (2025). *Heart failure: Symptoms and causes*. https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142

National Center for Biotechnology Information. (2023). *Heart failure (StatPearls)*. https://www.ncbi.nlm.nih.gov/books/NBK574497/

PubMed Central. (2024). *Heart failure and comorbidities*. https://pmc.ncbi.nlm.nih.gov/articles/PMC11739432/

UCSF Health. (2024). *Echocardiogram*. https://www.ucsfhealth.org/medical-tests/echocardiogram

Yale Medicine. (2024). *Acute decompensated heart failure*. https://www.yalemedicine.org/clinical-keywords/acute-decompensated-heart-failure