# Heart Failure Nursing Care Plan: Symptoms, Goals & Rationales

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A heart failure nursing care plan connects symptoms and fluid-status observations with agreed goals, monitoring, patient education and evaluation. This adult teaching example explains the reasoning behind each step. Fluid limits, dietary restrictions and medicines depend on the individual treatment plan.

Review fluid and electrolyte balance and lung sounds alongside the case. Return to the nursing care plan guide for the blank format and other examples.

Academic and clinical review pending. These original nursing care-plan examples support student learning, not patient-specific prescriptions or independent clinical decisions. Verify diagnostic terminology using your programme's approved references and follow local practice requirements.

- Assessment cues
- Priority nursing problems
- Measurable goals
- Interventions and rationales
- Worked clinical example
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- Common care-planning mistakes
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Related anatomy learning: For the underlying physiology of cardiac pumping and blood flow, see heart chambers, cardiac output and circulation in our complete BS Nursing Anatomy and Physiology I & II guide.

## Congestive heart failure: the same plan under its common name

"Congestive heart failure" is the name many textbooks and search results use for heart failure with fluid congestion -- the breathlessness, orthopnoea, waking at night short of breath, and swelling in the case above. It is not a separate condition and does not need a separate care plan. When a question or assignment asks for a congestive heart failure nursing care plan, this page is the answer: the fluid-volume assessment, the goals, the interventions, and the evaluation all apply as written. Where this page says "heart failure," read "congestive heart failure" wherever congestion signs are present.

## 1. Assessment: subjective and objective cues

Original fictional case: A 72-year-old patient with documented chronic heart failure

reports needing two pillows rather than one, fatigue during morning washing and swelling that has increased over several days. Their home weight log shows a rising trend compared with the individual stable baseline. Current blood pressure, pulse, oxygenation, medicines and renal history are available for review by the treating team.

Immediate priority: New breathlessness at rest, severe respiratory distress, chest pain, fainting or acute confusion warrants urgent assessment. New orthopnoea, oedema or weight gain should be communicated using the service's heart-failure escalation plan.

"Acute decompensated heart failure" means a sudden worsening -- new breathlessness at rest, rapid weight gain over days, or severe swelling in a previously stable patient. Treat it as an escalation, not as routine monitoring: use the urgent signs listed above, communicate through the service's heart-failure escalation plan, and do not wait for the next scheduled review.

**TABLE / Assessment cues, what they mean and why they matter**

| Assessment focus | What to document | Clinical reasoning |
|---|---|---|
| **Symptoms and trend** | **Breathlessness at rest or with exertion, orthopnoea, waking at night short of breath, swelling, fatigue, dizziness and changes from baseline.** | **Changes over time can matter more than a single snapshot.** |
| **Measurements and orders** | **Weight with consistent measurement conditions, fluid intake/output if prescribed, blood pressure, heart rate, respiration and relevant laboratory trends.** | **Weight and laboratory findings must be interpreted alongside the person's baseline and plan.** |
| **Function, safety and wellbeing** | **Activity tolerance, falls risk when dizzy, sleep, appetite, mood, comprehension, access to medicines and transport to follow-up.** | **Care outcomes include quality of life and feasibility, not only physiological values.** |
| **Multidisciplinary care plan** | **Read the current specialist summary, medicines list, monitoring plan, escalation thresholds and named contact.** | **NICE specifically recommends a coordinated individual heart-failure care plan.** |

## 2. Priority nursing problems

Differentiate a clinical observation from a verified nursing diagnosis. Use the current terminology when the individual's findings support it, and do not convert the medical diagnosis "heart failure" into a nursing diagnosis automatically.

### Priority consideration: Excessive fluid volume (00026)

Assessment support: a rising weight trend, increasing peripheral swelling and orthopnoea compared with baseline. Confirm: consistent weights and fluid observations when ordered,

cardiopulmonary findings, medicines, renal context, the team's assessment and alternative explanations. Oedema in isolation does not establish fluid excess.

Documentation principle: Describe the observed change, communicate suspected congestion, and specify an evidence-supported related factor before completing a formal problem-focused diagnosis statement.

### Conditional consideration: Decreased activity tolerance (00298)

Reported fatigue during washing suggests an activity-related problem, but confirm its extent, comparison with baseline and physiological response to exertion. The goal is meaningful participation in safely paced activity, not enforced bed rest.

### Discharge and medication-management needs

Assess knowledge and self-care capabilities rather than assuming the person has poor adherence. When an additional current-edition diagnosis is justified, record its own evidence and plan. See goals and interventions. Do not independently alter prescribed diuretics or impose fluid restrictions.

## NANDA nursing diagnoses commonly used in heart failure

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Use the current edition your programme requires (this page's references cite NANDA International 2024-2026) and confirm each diagnosis against the person's actual assessment -- a mediautomatically become any of these.

- Excess Fluid Volume (00026) -- when a rising weight trend, increasing oedema, and cardiopulmonary findings point to congestion, as in the case above.
- Decreased Cardiac Output (00029) -- when perfusion signs are present: hypotension, confusion, reduced urine output, or cool peripheries.
- Decreased Activity Tolerance (00298) -- when fatigue or dyspnoea on exertion clearly differs from the person's baseline.
- Ineffective Breathing Pattern (00032) -- when orthopnoea, paroxysmal nocturnal dyspnoea, or tachypnoea is documented.
- Risk for adult falls (00303) -- when dizziness or hypotension follows diuretic therapy or postural change; see the falls care plan for the full assessment.
- Readiness for Enhanced Health Self-Management -- when the person can learn weight and symptom monitoring with teaching and a written action plan.

Each diagnosis needs its own supporting evidence recorded before the plan is written; related factors and defining characteristics come from the assessment, not from the condition name.

## 3. Individualised, measurable nursing goals

| Timeframe | Expected outcome | Evaluation evidence |
|---|---|---|
| Current shift | Relevant worsening symptoms are communicated promptly and a personalised monitoring plan is documented. | Record timestamp, recipient, observations and response. |
| Before discharge or handover | Patient/carer demonstrates a reproducible way to monitor weight and symptoms and identifies their individual escalation instructions. | Use teach-back and confirm actual contact details. |
| During follow-up | Patient reports whether daily activities, breathlessness and swelling are improving, stable or worsening. | Compare with their agreed symptom diary and clinical review. |

Timeframes here are examples for a teaching scenario. A real patient's goals and monitoring frequency must be agreed using baseline information, actual orders and the responsible team's plan.

## 4. Nursing interventions with clinical rationales

**TABLE / Intervention, reasoning and evaluation: original nursing care plan table**

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| # | Nursing action | Why this action matters | Evidence of response |
|---|---|---|---|
| 1 | Monitor respiratory symptoms, positional breathlessness, oedema and changing functional capacity; communicate concerning changes. | New or worsening symptoms can signal decompensation or other illness requiring assessment. Clinical context: NICE NG106 chronic heart failure recommendations | Record the trajectory, not just "patient short of breath". |
| 2 | Follow the prescribed weight-monitoring plan with consistent scale, time and clothing; compare with the documented stable range. | Trend data can reveal changing fluid status before the person perceives all symptoms. Clinical context: NICE NG106 chronic heart failure recommendations | Document trends and the team's personal reporting threshold rather than imposing a universal number. |
| 3 | Review authorised fluid observations and any relevant renal, electrolyte or medication-monitoring results with the clinical team. | Fluid balance and treatment effects can interact with kidney function, blood pressure and electrolytes. Clinical context: NICE NG106 chronic heart failure recommendations | Escalate unexpected findings and record response. |

| # | Nursing action | Why this action matters | Evidence of response |
|---|---|---|---|
| 4 | Administer prescribed medicines with standard identity, allergy and administration checks; watch for hypotension, dizziness or reported adverse effects. | Heart-failure medicines require correct use and may have monitoring requirements; nurses support medication safety. Clinical context: NICE NG106 chronic heart failure recommendations | Document administration and refer concerns without changing doses independently. |
| 5 | Support paced activity and rest, with mobility review when safe. | Function can decline when the person overexerts or becomes unnecessarily inactive. Clinical context: NICE NG106 chronic heart failure recommendations | Ask what activities matter to them and record their response. |
| 6 | Deliver person-centred education on symptoms, medicines and follow-up, with teach-back and a written action plan. | NICE recommends an individual care plan including deterioration signs and access to the specialist team. Clinical context: NICE NG106 chronic heart failure recommendations | Ask the patient to explain whom they will contact if swelling, breathing or weight changes. |
| 7 | Review dietary and fluid advice from the treating plan; do not prescribe routine universal sodium/fluid limits. | NICE NG106 does not recommend routine blanket sodium or fluid restriction in all heart failure. Clinical context: NICE NG106 chronic heart failure recommendations | Document individually agreed advice and referrals to a dietitian when indicated. |

## Clinical reasoning flowchart

Assessment-to-evaluation pathway

Responsive original educational flowchart; not a treatment algorithm or clinical order.

## 5. Worked clinical documentation example

Example handover: "Baseline home weight recorded; three-day increase noted alongside worsening orthopnoea and ankle swelling. Current observations and medicines reconciled; treating team notified and symptom plan reviewed. Patient requests a clear written threshold for when to telephone the heart-failure nurse." Fictional information for teaching; not a clinical order.

How to adapt it: Replace all fictional findings with the current person’s verified assessment and authorised plan. Keep the patient’s own preferences, language and abilities visible in your documentation. Do not paste an example note directly into a patient record.

## Heart failure monitoring: connect the trend to the symptoms

A fictional patient reports increasing ankle swelling, extra pillows at night and a rising home-weight trend. Review these findings together and communicate worsening breathlessness promptly.

**TABLE / A useful heart-failure monitoring record**

| Record | Why it matters |
|---|---|
| Weight, date and measurement conditions | A series of comparable measurements is more useful than an unexplained isolated number. |
| Breathlessness, swelling and usual activity | The patient's ability to sleep and carry out daily tasks gives context to the weight trend. |
| Prescribed medicines taken, missed doses and difficulties | A nonjudgmental conversation may reveal side effects, cost, access or misunderstanding that the team can address. |
| Agreed reporting threshold and contact route | The patient needs to know when and how to seek help, using their own care plan. |

A lower weight does not by itself prove improvement if dizziness or other concerns develop. Review symptoms and relevant observations with the team. Follow the agreed plan for salt and fluid intake; NICE does not recommend routine restriction for every person with heart failure. Review fluid-balance assessment alongside this case.

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## Left-sided vs right-sided heart failure: what changes in the plan

Many patients have signs of both sides, and biventricular failure means exactly that. The plan follows the patient's actual signs, not the label -- but the emphasis shifts:

- Left-sided: breathlessness, orthopnoea, waking at night short of breath, crackles, cough and fatigue -- the plan emphasises respiratory monitoring, positional breathlessness, paced activity and escalation for new rest dyspnoea.
- Right-sided: peripheral oedema, jugular venous distension, abdominal swelling and rapid weight gain -- the plan emphasises daily weights under consistent conditions, oedema checks and fluid-balance review with the team.

In left-sided failure, watch the breathing and activity tolerance first. In right-sided failure, watch the weight trend and swelling first. Either side can decompensate, and the escalation thresholds in Section 1 apply to both.

## 6. Evaluation: did the interventions work?

Evaluation includes symptom direction, activity tolerance, adherence barriers, blood pressure and the clarity of the discharge plan. A goal is not automatically achieved

because weight falls while dizziness or renal concerns appear. Reassess with the multidisciplinary team and update the person's agreed plan.

## 7. Common mistakes to avoid

- Universal 1-litre fluid or sodium restrictions without an individual order.
- Prescribing a blanket weight-gain threshold instead of the patient's action plan.
- Assuming ankle oedema alone proves cardiac decompensation.
- Failing to establish contact details for follow-up or worsening symptoms.

## 8. Frequently asked questions

### Why are daily weights used in heart-failure care?

A consistent weight trend may help identify fluid changes. It must be interpreted alongside symptoms, individual baseline and the clinician-approved action plan.

### Should every patient with heart failure restrict fluids?

No. NICE guidance advises against routine restriction for all; restrictions may be appropriate in selected circumstances under the clinical plan.

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### Which nursing interventions support heart-failure self-care?

Monitoring symptoms, supporting prescribed medicines, teaching safe weight tracking, identifying individual red flags and coordinating follow-up are central examples.

### What does an effective evaluation look like?

It considers respiratory comfort, swelling, activity, adverse effects, trend data and the person's ability to explain their response plan.

### Is a congestive heart failure nursing care plan different from a heart failure care plan?

No. "Congestive heart failure" is the common name for heart failure with fluid congestion -- breathlessness, orthopnoea, and swelling. The assessment, goals, interventions, and evaluation are the same, and this page covers both terms.

### What are the NANDA nursing diagnoses for heart failure?

The ones most often supported by assessment are Excess Fluid Volume (00026), Decreased Cardiac Output (00029), Decreased Activity Tolerance (00298), and Ineffective Breathing Pattern (00032), with Risk for adult falls (00303) and Readiness for Enhanced Health

Self-Management where the findings fit. Each needs its own evidence from the person's assessment, using your programme's current NANDA edition -- the medical diagnosis alone does not establish any of them.

### What are common nursing interventions for heart failure?

Monitor respiratory symptoms and oedema, follow the prescribed weight-monitoring plan, review fluid observations and relevant laboratory trends with the team, support medication safety, pace activity with rest, deliver person-centred education with teach-back and a written action plan, and use only the fluid and sodium advice the treating plan specifies. Section 4 gives each intervention with its rationale.

### What goals go in a heart failure nursing care plan?

Typical goals: worsening symptoms are communicated promptly with a documented monitoring plan (this shift); the patient or carer demonstrates weight and symptom monitoring and can name their escalation contact (before discharge); and symptoms, activity, and swelling are reviewed as improving, stable, or worsening (at follow-up). Section 3 shows the full table with evaluation evidence.

### How does the care plan differ for left-sided and right-sided heart failure?

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Left-sided failure emphasises breathing and activity -- dyspnoea, orthopnoea, crackles, and paced exertion. Right-sided failure emphasises fluid -- daily weights, oedema checks, and fluid-balance review. Many patients show both, and the plan follows the actual signs; escalation thresholds apply to either side.

Related clinical skill: Vital signs and escalation nursing guide

## 9. Evidence and further reading

- NICE NG106: Chronic heart failure -- personalised care plans
- American Heart Association: Managing symptoms
- American Heart Association: Changes to report
- Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2024). NANDA International Nursing Diagnoses: Definitions and Classification, 2024-2026 (13th ed.). Thieme. Reference edition.

Evidence notes: clinical recommendations are interpreted for general nursing education and may need revision when national or local guidance changes. Sources are linked so readers can check the current wording.

Source: https://mynursinghub.com/nursing-care-plans/heart-failure-nursing-care-plan/