Nursing diagnosis	Assessment	Intervention	Expected outcome
Decreased cardiac output related to altered heart rate, rhythm as manifested by increase heart rate and urine output.	1.Assess vital signs, cardiac rhythm. 2. Monitor pluses and peripheral perfusion. 3. Monitor patient conscious level. 4. Assess of respiratory rate.	1.Administer medication as Dr order. 2.Put patient on oxygen supply 1. 3. Instruct on ways to reduce work of the heart. 2. 4. Educate on risk factor and lifestyle modification.	• Absence shortness of breathing • Stability of renal perfusion and cardiac output within normal. • Reduce workload of the heart.

Excess fluid volume related to fluid and sodium intake as manifested by weight gain edema in extremities	1. Assess for peripheral edema and jugular vein distended. 2. Monitor breathe and heart sound. 3. Monitor urine output. 4. Monitor of central venous pressure.	1. Maintain upright position will help patient breathe easier and more comfortable. 2. Administer diuretics as physician order. 3. Instruct patient to decrease sodium and fluid. 4. Teach patient how to monitor for fluid volume overload.	Stable fluid volume through balance intake and output Normal baseline body weight Absence of peripheral edema Patient maintain of fluid restriction.
Impaired gas exchange related to pulmonary congestion due to fluid retention as manifested by dyspnea and abnormal ABG	1. Auscultate of chest sound found crackles and wheezes. 2. Monitor signs of hypoxemia	1. Educate on coughing and deep breathing exercise. 2. Chest Physiotherapy if need. 3. Change patient position help to drainage secretion.	Improve patient perfusion. Improve ventilation assessed by normal ABG.

	3. Monitor arterial blood gases. 4. Assess of patient signs of tachypnea 5. Monitor signs of respiratory distress.	4. Maintain semi setting position and patient mobilization if	Patient able to walk with slightly help Improve of oxygen saturation