DVT Nursing Care Plan

Patient Name: Date:

- [ ] **Nursing Diagnosis #1: Ineffective Tissue Perfusion**

Related to:

- [ ] Venous stasis
- [ ] Damage to the vessel wall
- [ ] Blood hypercoagulability

As evidenced by:

- [ ] Edema
- [ ] Pain
- [ ] Increased warmth to the site of the clot
- [ ] Tenderness

Expected Outcomes:

- Patient will be free of pulmonary embolism as evidenced by the absence of shortness of breath or chest pain.
- Patient will maintain optimal tissue perfusion in the affected area as evidenced by decreased pain, sufficient capillary refill, and strong peripheral pulses.

Assessment:

- Assess for signs and symptoms. DVT may be asymptomatic, but assess for edema, pain, tenderness, color changes, skin temperature, capillary refill, and palpated pulses.
- Assess the patient's risk factors. Identify possible causes of DVT, such as recent surgery, immobility, trauma, obesity, pregnancy, and dehydration.
- Measure leg circumference. Measure the affected leg below the tibial tuberosity and above the patella to detect any significant differences.

Interventions:

1. Administer anticoagulants as ordered. Monitor lab values routinely to achieve and maintain therapeutic levels.
2. Apply compression stockings as ordered to promote venous circulation and reduce the risk of clot formation.
3. Ensure adequate hydration to reduce blood viscosity. Encourage the patient to drink sufficient fluids.

☐ **Nursing Diagnosis #2: Risk For Bleeding**

Related to:

☐ Use of anticoagulants

☐ Abnormal blood profiles

Expected Outcomes:

- Patient will maintain therapeutic levels of blood clotting factors.
- Patient will verbalize safety measures to prevent bleeding.
- Patient will not experience bleeding.

Assessment:

- Assess vital signs and symptoms of bleeding, including hypotension, tachycardia, hypothermia, dizziness, nosebleeds, gum bleeding, and bruising.
- Monitor labs, including platelet count and coagulation profiles (PT, PTT, INR).
- Monitor heparin-induced platelet aggregation (HIPA) status to identify heparin-induced thrombocytopenia (HIT).

Interventions:

1. Provide education to reduce bleeding risk, including using a soft toothbrush and electric razors and avoiding forceful coughing or nose blowing.
2. Take immediate action if bleeding occurs. Stop heparin infusion, notify the doctor, evaluate labs, and adjust heparin dosage based on results.
3. Provide education on bleeding precautions for patients taking oral anticoagulants at home. Have antidotes available to reverse anticoagulants in case of severe bleeding.

☐ **Nursing Diagnosis #3: Deficient Knowledge**

Related to:

☐ Unfamiliarity with diagnosis or prevention

☐ Poor knowledge of risk factors

☐ Lack of interest

As evidenced by:

- Verbalization of questions about diagnosis
- Misadministration of medications
- Poor follow-through with routine lab work
- Recurrent DVT

Expected Outcomes:

- Patient will verbalize an understanding of diagnosis and treatment.
- Patient will verbalize the importance of medications and follow-up lab tests.
- Patient will identify their risk factors and three ways to prevent recurrent DVT.

Assessment:

- Assess knowledge about risk factors and evaluate readiness to adhere to medications.
- Assess understanding of follow-up care, including the importance of routine lab testing.

Interventions:

1. Explain the signs of pulmonary embolism and emphasize the need for immediate medical attention.
2. Discuss individual risk factors and ways to decrease the risk, such as avoiding prolonged sitting and smoking.
3. Provide education about medications, emphasizing proper dosage, frequency, and reasons for each.
4. Teach ways to prevent recurrence, including avoiding leg crossing and taking breaks on long flights or car rides.