### NURSING PROCESS FOCUS  Clients Receiving Direct Vasodilator Therapy

<table>
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<th>Assessment</th>
<th>Potential Nursing Diagnoses</th>
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| Prior to administration:  
  ■ Obtain a complete health history including allergies, drug history, possible drug interactions, and especially impaired cardiac/cerebral circulation.  
  ■ Obtain an ECG and vital signs.  
  ■ Auscultate heart and chest sounds.  
  ■ Assess neurological status and level of consciousness.  
  ■ Obtain blood and urine specimens for laboratory analysis. | ■ Tissue Perfusion, Ineffective  
■ Fluid Volume, Excess  
■ Injury, Risk for, related to orthostatic hypotension  
■ Skin Integrity, Risk for Impaired, related to infiltration of IV medication  
■ Knowledge, deficient, related to drug therapy |

### Planning: Client Goals and Expected Outcomes

The client will:  
■ Exhibit a reduction in systolic and diastolic blood pressure.  
■ Demonstrate an understanding of the drug’s action by accurately describing drug side effects and precautions.

### Implementation

<table>
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<th>Interventions and (Rationales)</th>
<th>Client Education/Discharge Planning</th>
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<tr>
<td>■ Observe for signs and symptoms of lupus. (These are side effects of the drug.)</td>
<td>■ Instruct client to report classic “butterfly rash” over the nose and cheeks, muscle aches, and fatigue when taking hydralazine.</td>
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| ■ Monitor vital signs every 5 to 15 minutes and titrate infusion based on prescribed parameters and be prepared to treat reflex tachycardia if it occurs. (These drugs cause rapid hypotension and reflex tachycardia.) | ■ About the purpose of treatment and reassure the client during emergency care.  
■ To report feelings of rapid heart rate, dizziness, or faintness. |
| ■ Observe for IV infiltration. (Direct vasodilators can cause tissue destruction if infiltration occurs.) | ■ Instruct client to report any burning or stinging pain, swelling, warmth, redness, or tenderness at IV insertion site. |
| ■ Monitor cardiac/cerebral circulation. (Hypotension produced by vasodilators may further compromise individuals who already suffer from ischemia.) | ■ Instruct client to:  
■ Report angina-like symptoms: chest, arm, back and/or neck pain, palpitations.  
■ Report faintness, dizziness, drowsiness, any sensation of cold, numbness, tingling, pale or dusky look to the hands and feet.  
■ Report headache or signs of stroke: facial drooping, visual changes, limb weakness, or paralysis.  
■ Monitor vital signs (especially blood pressure) daily after discharge. |
| ■ Monitor for hypotension and dizziness. (Direct vasodilators may cause decreased circulation to the brain.) | ■ Instruct client to:  
■ Avoid driving or other activities requiring mental alertness or physical coordination until effects of the drug are known.  
■ Rise from a sitting or lying position slowly to avoid dizziness. |
| ■ Evaluate for needed lifestyle modifications. (Lifestyle modifications are effective in reducing HTN.) | ■ Instruct client to comply with additional interventions for HTN such as weight reduction, modification of sodium intake, smoking cessation, exercise, and stress management. |
| ■ Discontinue medication gradually. (Abrupt withdrawal of drug may cause rebound hypertension and anxiety.) | ■ Instruct client to not stop taking drug suddenly. |

### Evaluation of Outcome Criteria

Evaluate the effectiveness of drug therapy by confirming that client goals and expected outcomes have been met (see “Planning”).  
■ The client’s blood pressure is within normal limits.  
■ The client demonstrates an understanding of the drug’s actions by accurately describing drug side effects and precautions.

⚠️ See Table 23.8 for a list of drugs to which these nursing applications apply.