Hypertension Nursing Care Plan

A five-column plan that treats the two things that actually move blood pressure in practice: correct measurement technique and the patient's real adherence barrier.

QUICK ANSWER

For hypertension, prioritize: risk for decreased cardiac tissue perfusion → ineffective health management → deficient knowledge → imbalanced nutrition → risk for impaired renal function. Core interventions are correct BP technique (seated 5 min, correct cuff, two readings averaged), identifying the actual adherence barrier before adding a drug, validated home BP monitoring, DASH with a 1,500 mg sodium goal, guideline-directed therapy with K^+/creatinine recheck at 2–4 weeks, and nurse-led follow-up. Target below 130/80 mmHg.

Assessment (subjective + objective)

Subjective: occipital morning headache, "I stopped my pills because they made me pee all night", no home BP monitor, adds salt at the table, sedentary, 12 pack-year smoking history, reports work stress and poor sleep.

Objective: BP 168/98 (repeat 164/96 after 5 min rest, correct cuff size), HR 84, BMI 33.4, waist 42 in, LDL 158, HbA1c 6.1%, urine albumin/creatinine 42 mg/g, retinal arteriolar narrowing, ECG with LVH voltage criteria.

Priority NANDA-I diagnoses

1. **Risk for decreased cardiac tissue perfusion** AEB sustained BP 168/98, LVH on ECG, and LDL 158.

2. Ineffective health management related to medication side effects and absent self-monitoring AEB self-discontinuation of antihypertensive therapy.
3. Deficient knowledge regarding sodium intake, DASH pattern, and home BP technique.
4. Imbalanced nutrition: more than body requirements AEB BMI 33.4, waist 42 in.
5. Risk for impaired renal function AEB albumin/creatinine 42 mg/g.

NOC outcomes (SMART)

- Office BP < 130/80 within 12 weeks (per 2017 ACC/AHA target).
- Patient submits ≥ 12 home BP readings using correct technique before the 4-week visit.
- Patient states three high-sodium foods to avoid and the 1,500 mg/day sodium goal before discharge from clinic.
- Patient reports ≥ 150 min/week of moderate activity by week 8.
- Weight loss ≥ 5% of body weight by 6 months.

NIC interventions and rationale

- **Measure BP with correct technique: seated 5 min, back supported, arm at heart level, correct cuff size, two readings averaged** — improper technique routinely overestimates BP by 10–20 mmHg and drives unnecessary escalation.
- **Elicit and address the actual adherence barrier before adding a drug** — this patient stopped a diuretic for nocturia; morning dosing or a switch to an ACEi/CCB solves it without another prescription.
- **Teach and validate home BP monitoring; give a written log or app** — home readings predict cardiovascular outcomes better than office readings and improve adherence.

- **DASH pattern with 1,500 mg sodium goal; review label reading and the top sodium sources (bread, deli meat, canned soup, pizza, sauces)** — DASH plus sodium restriction lowers SBP 8–14 mmHg, comparable to a first-line drug.
- **Reinforce guideline-directed pharmacotherapy (thiazide, ACEi/ARB, dihydropyridine CCB) and check K^+/creatinine 2–4 weeks after any change**.
- **Screen for and treat sleep apnea, and assess alcohol, NSAID, and decongestant use** — common reversible contributors to resistant hypertension.
- **Teach hypertensive urgency warning signs: chest pain, focal weakness, vision change, severe headache, dyspnea**.
- **Schedule nurse-led follow-up at 2–4 weeks after any medication change** — structured nurse-led titration clinics achieve control faster than usual care.

Evaluation

At week 12: office BP 128/78, 26 home readings logged with correct technique, patient names four high-sodium foods and reports 180 min/week walking, weight down 4.1 kg (4.6%). Outcomes 1–4 met; weight-loss outcome on track and continued to 6 months.

Frequently Asked Questions

What blood pressure target should the care plan use?

The 2017 ACC/AHA guideline sets a target below 130/80 mmHg for most adults, including patients with diabetes or chronic kidney disease. Check your program's required guideline; some courses still teach 140/90 for older adults.

Is there a NANDA diagnosis called 'hypertension'?

How much can lifestyle change actually lower blood pressure?

Weight loss lowers SBP roughly 1 mmHg per kilogram, the DASH diet 8–14 mmHg, sodium restriction 5–6 mmHg, aerobic exercise 4–8 mmHg, and limiting alcohol about 4 mmHg. Stacked, they rival dual drug therapy.

What should I teach about home blood pressure monitoring?

Sources & Further Reading

1. **Whelton, P. K., et al..** 2017 ACC/AHA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. Hypertension, 71(6), e13–e115.
2. **Appel, L. J., et al..** Effects on blood pressure of reduced dietary sodium and the DASH diet. New England Journal of Medicine, 344(1), 3–10.

Related Resources

→ Full nursing care plan library→ Heart failure care plan→ Stroke care plan→ Type 2 diabetes care plan