Community nursing note

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Patient ID	P005	**Document ID**	P005-D05
Date	2026-08-31	**Type**	Community nursing note
Author	Nursing	**Recipient**	-

Date: 31 August 2026

Patient: Grace O'Connor

Location: Patient home

Service: Community nursing - home follow-up

Reason for visit

Post-discharge review to monitor response to the temporary increase in oral furosemide, following ED discharge on 28 August 2026 for mild heart failure decompensation.

Background

Grace lives alone and receives weekly community nurse support. Relevant history includes heart failure with reduced ejection fraction, chronic kidney disease stage 3 and hypertension. She is allergic to spironolactone (previous hyperkalaemia). Current medications include bisoprolol 2.5 mg once daily, furosemide 80 mg each morning (temporary increase from 40 mg, commenced 28 August 2026 for a 5-day course) and sacubitril/valsartan 24/26 mg twice daily.

Observations this visit

- Weight down 2.2 kg since the previous recording.
- Oedema reduced.
- No dizziness reported.

Patient-reported information

Grace reports no dizziness. No other new symptoms were reported by her at this visit.

Clinical impression

Responding to treatment.

Care provided and advice

Weight and symptom review completed. No change to medications was made at this visit. Grace was advised to continue the temporary furosemide dose until the planned end date, and to continue daily morning weight recording as previously instructed. She was reminded to seek review for breathlessness at rest, chest pain or reduced urine output.

Follow-up

- Daily weight and symptom monitoring by community nursing remains outstanding, due 3 September 2026.
- Repeat renal function and potassium requested through the GP, due 3 September 2026 - outstanding.
- Heart failure clinic review scheduled for 24 September 2026 - outstanding.

No escalation was required at this visit.

Community Nurse

Community Nursing Service