N210 Care Plan

Lindsey Platt

2/14/19

Patient Demographics

Age: 82   Gender: F

Place of Residence: 150

Code Status: DNR

Date of Admission: 3/9/18

Social History

Marital status: widowed

Occupation: former teacher

Tobacco use: smoked for 2-3 years

Alcohol use: none

Substance abuse: none

Past History

Past Medical History:
HTN
Hyperlipidemia
Lack of coordination
Repeated falls
Aphasia
Cerebral infarction
Muscle atrophy
Abnormalities of gait and mobility

Past Surgical History:
Right artificial hip joint replacement surgery

Allergies: NKA

History of Present Illness

Subjective complaint: The patient states "I can't live by myself."

HPI:

The patient is a 82 year old female who has dementia, she is not on Harmony side because she cannot walk. She uses a wheelchair. She was able to wheel herself to the cafeteria for meals. She claims she is not in any pain. However, when giving her a morning shower, I noticed a blister-like rash on her chest and lower torso that a doctor looked and and prescribed hydrocortisone cream.

Medical Diagnosis/Acute Problem(s): cerebral infarction

Current Treatments:

AmLODIPine Besylate give 2 5mg tablets by mouth in the morning for HTN

Aspirin tablet delayed release 325mg once in the morning for heart health

Benazepril HCl 40mg give 1 tablet by mouth in the morning for HTN

HydroCHLOROthiazide 25mg give 1 tablet by mouth in the morning for diuretic

Hydrocortisone cream 1% apply to upper chest and shoulders for itching until healed

Metoprolol Tartrate tablet 50 mg give 1 tablet by mouth 2 times a day for HTN, hold if BP is below 100/60 or pulse below 60

PROzac Capsule 20 mg give 1 capsule by mouth in the morning for depression

Rosuvastatin Calcium tablet 20 mg give 1 tablet by mouth at bedtime for hyperlipedemia

Pathophysiology

Medical Diagnosis/Acute Problem: aphasia following cerebral infarction

Describe the pathophysiology. Include risk factors, clinical manifestations, appropriate diagnostics, and recommended treatments.

A stroke, cerebrovascular accident (CVA), or brain attack is the sudden disruption of O2 supply to the brain. This can be due to rupture in one or more of the blood vessels that supply the brain or loss of cerebral perfusion often resulting from hypoperfusion or reduction of O2 supply (Swearingen, 2018, p. 329).

Risk factors include TIAs; hypertension; atherosclerosis; high serum cholesterol or triglycerides; high homocysteine levels; diabetes mellitus; gout; smoking; obesity; cardiac valve diseases, such as those that may result from rheumatic fever, valve prosthesis, and atrial fibrillation; cardiac surgery; blood dyscrasias; anticoagulant therapy; neck vessel trauma; oral contraceptive use; cocaine or methamphetamine use; family predisposition for arteriovenous malformation (AVM); aneurysm; advanced age; or previous stroke (Swearingen, 2018, p. 330).

Clinical manifestations vary with the size and site of injury and may improve in 2-3 days as the cerebral edema decreases. Changes in mentation, including apathy, irritability, disorientation, memory loss, withdrawal, drowsiness, stupor, or coma; bowel and bladder incontinence; numbness or loss of sensation; weakness or paralysis on part or one side of the body; aphasia; headache; neck stiffness and rigidity; vomiting; seizures; dizziness or syncope; ataxia; and fever may occur. A brain stem infarct leaving the patient completely paralyzed with intact cortical function is called locked-in syndrome. With cranial nerve involvement, visual disturbances include diplopia, blindness, and hemianopia. Inequality or fixation of the pupils, nystagmus, tinnitus, and difficulty chewing and swallowing also occur. Physical assessment: Papilledema, arteriosclerotic retinal changes, or hemorrhagic retinal areas on ophthalmic examination, hyperactive deep tendon reflexes (DTRs), decreased superficial reflexes, and positive Babinski's sign (Swearingen, 2018, p. 330).

Diagnostic tests include CT scan, MRI scan, lab tests such as serum electrolytes and CBC, electrocardiogram, transcranial doppler ultrasound, swallowing examination, positron emission tomography, electroencephalograph, cerebral angiography, evoked response test, and electronystagmography (Swearingen, 2018, p. 331).

Recommended treatments include IV injection of tissue plasminogen activator (tPA), medications delivered directly to the brain, removing the clot with a stent retriever, and carotid endarterectomy (Stroke, 2018).

Describe the pathophysiology specifically as it relates to **<u>YOUR</u>** patient. Include discussion on signs and symptoms as well as the results of any relevant diagnostic tests.

My patient has hypertension which is a huge risk factor for having a stroke. She is on amLODIPine and Benazepril for her hypertension. Another risk factor is advanced age and my patient is 82. Some of the clinical manifestations my patient shows include bladder incontinence, she voided as we were getting her up for her shower; memory loss, I had to ask her questions multiple times and remind her multiple times that it was shower time, meal time, etc.; and drowsiness, she slept in longer than what she usually does in the morning. My patient also gets a CBC every 6 months, her last one was in October but I could not get record of those results.

Physical Assessment

Vital Signs: T: 98.4 degrees temporal P: 61 RR: 12 O2Sat: 95% BP: 136/68	Pain: none	Intake & Output: For breakfast, ate toast and eggs Voided once in the morning and no BM

NEUROLOGICAL: MAE: Y N PERLA: **Y** N Strength Equal: Y N if no - Legs Arms Both Orientation, Mental Status, Speech, Sensory, LOC: A+Ox1, just knew her name, nothing else **EENT:** Ears: no hearing aids Eyes: no glasses Nose: normal Teeth: no dentures	**GASTROINTESTINAL:** Diet at home: __normal_____ Current Diet: _____normal_____ Height: _____62"_____ Weight: _____107 lbs_____ Auscultation: ____active in all 4 quadrants_____ Last BM, character & freq of stools _____ Palpation: Pain, Mass etc ___no pain_____ Inspection: NO distention, incisions, scars, drains, wounds Ostomy: Y **N** Nasogastric: Y **N** Feeding tubes/PEG tube Y **N** Type:_____

MUSCULOSKELETAL:
Neurovascular status, ROM, Supportive devices/strength: Passive ROM
 	
ADL Assistance   Y N   Fall Risk: **Y** N   Morse Fall Scale: 70
Activity/Mobility Status:
        Needs assistance with equipment   uses a wheelchair
        Cannot stand or walk
	GENITOURINARY:
	Color, character, quantity of urine,
	Pain : Y **N** Describe: _____
	Dialysis Y **N**
	Inspection of genitals:
	Catheter: Y **N** Type_____

CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. __S1 and S2 sounds heard_____ Cardiac rhythm (if applicable) _____ Peripheral Pulses 2+ bilaterally, Capillary refill less than 3 seconds Neck Vein Distention: Y **N** Edema Y **N** Location of Edema_____	**PSYCHOSOCIAL/CULTURAL:** Coping methods:___I just sit here _____ Educational level: ___college_____ Developmental level: __elderly_____ Ethnicity: ___caucasian_____ Religion & what it means to pt. ____no preference_____ Occupation (previous if retired) ___former teacher_____ Personal/Family Data (Think about home environment, family structure, and available family support):pt states that she has 2 kids that visit her Do you feel safe at home? **Y** N
RESPIRATORY: Accessory muscle use: Y **N** Breath Sounds: Location, character ___clear throughout all lung fields_____	**INTEGUMENTARY:** Skin color, character, turgor, rashes, bruises, wounds: character, drainage, approximation etc.: She had a blister-like rash on her chest and lower torso. She said that she had been itching a lot in the night, the doctor prescribed her anti-itch cream. Braden scale: ____13_____. Also date & location of IV's: no IVs

The Nursing Process

Nursing Diagnosis #1 (Physical): Impaired physical mobility r/t neuromuscular impairment with limited use of lower limbs   ___

Outcome Planning: The patient will demonstrate techniques that promote ambulating and transferring.

Nursing Interventions	Client Responses to Interventions
1. Assess the patient's strength	1. I asked the patient to push up on my hands with her legs and her arms, her legs were weaker than her arms were
2. Assess BP	2. It was 136/68, which is high, she couldn't tell me if she had gotten her medication yet.
3. Assess pedal pulse	3. Normal 2+
4.Recommend TED hose	4.She was not prescribed TED hose however, she had long, tight fitting socks
5. Ambulate patient to and from wheelchair.	5. She was a 2 person assist.

Evaluation (client progress): She neither progressed or regressed, she was able to get to the cafeteria by herself, goal was met.

Nursing Diagnosis #2 (Safety): Impaired verbal communication r/t aphasia with cerebral infarction

Outcome Planning: The patient demonstrates communication to the best of her abilities

Nursing Interventions	Client Responses to Interventions
1. Let the patient know it is time for meals	1.She had to be reminded a couple times
2.Ensure the patient is well rested	2.We let the patient sleep in longer than what she usually does
3.Give the patient a shower	3.She couldn't express if she wanted one or not but she said it felt good in the shov
4.Communicate with the patient as much as possible, use gestures and facial expressions	4.I repeated myself a couple times so she could understand me better along with sh my head for yes and no
5.Let the patient complete their sentences	5.When asking what she ate for breakfast, she said we "had to come back to that or After asking a few more, I asked it again and she said she had eggs and toast.

Evaluation (client progress): She communicated better in the morning and less as the day went on, goal was met.

Swearingen, P. L. (2018). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental*

   health. Place of publication not identified: MOSBY.

2018. Stroke- diagnosis and treatments. Retrieved from https://www.mayoclinic.org/diseases-conditions/stroke/diagnosis-treatment/drc-20350119