N441 Care Plan

Lakeview College of Nursing

Kristine Johnson

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/13/2020	E.M.E.	83	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Homemaker	Widow	Morphine, Eucalyptus, clincril, hydrocodone, metformin, Zestril (lisinopril)
Code Status	**Height**	**Weight**	
DNR no ACP docs	1.575m (5'2")	67.1 kg	

Medical History (5 Points)

Past Medical History: amblyopia, anemia, aneurysm iliac common artery, arthritis, BCC, calculus of kidney, colitis, diabetes type 2, diabetic nephropathy, benign essential hypertension, glaucoma, goiter, history of lung surgery, hyperlipidemia, immunocompromised, macular degeneration, malignancy, melanoma, MS, pancreatic cyst, periodic limb movement disorder, peripheral artery disease, personal history of steroid therapy, skin cancer, essential tremor, unspecified adjustment reaction, unspecified hereditary and idiopathic peripheral neuropathy.

Past Surgical History: breast biopsy, cataract removal w/ implant right and left, colonoscopy, eye surgery, hysterectomy, intravitreal injection, lithotripsy, lung removal partial, lung surgery, patella surgery, PR atherectomy, open FEM POP, PR ulnar nerve at elbow, skin cancer excision, tonsillectomy, ureteroscopy

Family History: Father (passed)- heart/ stoke. Mother (passed)- allergies. Brother- Alzheimer's, cancer, heart, hypertension, and lipids. Sister- cancer, glaucoma, macular degeneration, lung, and melanoma.

Social History (tobacco/alcohol/drugs): former smoker- quit 1975, 0.5 packs/day for 15 years, drinks 2-3 glasses of wine occasionally, and no drug use.

Assistive Devices: walker / wheelchair

Living Situation: Lives in own home

Education Level: Highschool

Admission Assessment

Chief Complaint (2 points): Left sided weakness

History of present Illness (10 points): Client 83 years old very pleasant, history of MS essential hypertension, type 2 diabetes present with worsening left sided weakness in last 2 days. Patient is very emotional, and she had slurring of speech so daughter who is present at bedside also contributed to history. Client was last known normal 9/11/20 at bedtime. Client noticed some weakness on her left leg but was able to walk on her own but was feeling a little off. Weakness gradually progressed throughout the day and she needed a walker. She also had weakness on her left side of the face. Both patient and the daughter attributed the symptoms to MS flare. Symptoms progressively worsened today (9/13/20) she required a wheelchair due to significant weakness on her left side and EMS was called as they were concerned about stoke. She had a headache 2 days ago. At baseline she is legally blind due to macular degeneration but there is no worsening vision changes. In ED she was noted to have significant weakness on her left upper and lower extremity with left facial droop and slurring of speech. Neurology contacted. MRI of brain showed acute right paramedian pontine. Patient has a history of MS and she was on disease modifying agent for 40 years and 4 years ago stopped. Intermitted MS flares for which she takes prednisone. Last flare was a year ago during the spring.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Stoke (Cerebrum) (CMS-HCC)

Secondary Diagnosis (if applicable):N/a

Pathophysiology of the Disease, APA format (20 points):.

The client this nursing student took care of is primarily diagnosed with a stroke, which affected her brain's right hemisphere, leaving weakness on her left side. When assessing with the client, the differences in strength from her left and her right with her left had little to no ability to move. This condition occurs when there is a blockage, or there is less blood going to the brain, decreasing the oxygen supply, and within minutes of this happening, brain cells begin to die *(Stroke - Symptoms and Causes - Mayo Clinic, 2020).* The signs and symptoms include trouble speaking and understanding what others are saying; paralysis or numbness of the face, arms, or leg, problems seeing in one or both eyes; headache, and trouble walking(*Stroke - Symptoms and Causes - Mayo Clinic, 2020*). The client was experiencing a headache two days before the stroke was diagnosed. She also experienced trouble speaking from the facial drooping, numbness and weakness in both extremities on her left side, and difficulty walking because of the defect on her left side-effecting her leg. The client was diagnosed with her stroke by MRI, where the results found acute right paramedian pontine, which caused the blockage in the brain resulting in a stroke for the client *(Kataoka et al., 1997).* Treatments for stroke for this client will include speech therapy, physical therapy, and possibly re-examination of medication to prevent future stroke episodes. Medicines for treatment can consist of being placed on the aspirin regimen, which the client was placed on while in the hospital, and this to make blood thinner prevent blood clots from causing a blockage in the arteries *(Mclntosh, 2020*). The future treatment they provide will need to discuss with the client would be considering occupational therapy to potentially return to her previous activities (*Mclntosh, 2020*). The nurse can help suggest support groups for mental health since this condition dramatically alters the face and can affect the client's perceptions of self (*Mclntosh, 2020).*

Pathophysiology References (2) (APA):

Kataoka, S., Hori, A., Shirakawa, T., & Hirose, G. (1997). Paramedian pontine infarction. *Stroke*, *28*(4), 809–815. Retrieved September 19, 2020, from https://doi.org/10.1161/01.str.28.4.809

Mclntosh, J. (2020, March 11). *Stroke: Causes, symptoms, diagnosis, and treatment*. Medical News Today. Retrieved September 19, 2020, from https://www.medicalnewstoday.com/articles/7624

Stroke - symptoms and causes - mayo clinic. (2020, August 8). Mayo Clinic. Retrieved September 19, 2020, from https://www.mayoclinic.org/diseases-conditions/stroke/symptoms-causes/syc-20350113

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.50-5.20**	**4.57**	**N/a**	
Hgb	**11.0-16.0**	**13.7**	N/a	
Hct	**34-47**	**42.5**	N/a	
Platelets	**140-400**	**213**	N/a	
WBC	**4.00-11.00**	**6.57**	N/a	
Neutrophils	**1.60-7.70**	**4.38**	N/a	
Lymphocytes	**1.00-4.90**	**1.40**	N/a	
Monocytes	**0.00-1.10**	**0.44**	N/a	
Eosinophils	**0.00-0.50**	**0.29**	N/a	

Bands	**45-74%**	**N/a**	N/a	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**135-145**	**140**	**N/a**	
K+	**3.5-5.0**	**4.2**	**N/a**	
Cl-	**98-107**	**105**	**N/a**	
CO2	**21.0-32.0**	**32.6**	**N/a**	**Client has a history of lung disease and surgery which can cause impaired gas exchange making the CO2 elevated**
Glucose	**60-99**	**157**	**169**	**The client is a type 2 diabetic and if uncontrolled though diet the blood glucose can be high**
BUN	**7-18**	**10**	**N/a**	
Creatinine	**0.55-1.02**	**0.80**	**N/a**	
Albumin	**3.4-5.4**	**3.5**	**N/a**	
Calcium	**8.5-10.1**	**9.3**	**N/a**	
Mag	**1.6-2.6**	**2.2**	**N/a**	
Phosphate	**2.4-4.5**	**N/a**	**N/a**	
Bilirubin	**0.2-1.2**	**N/a**	**N/a**	
Alk Phos	**20-140**	**N/a**	**N/a**	
AST	**10-40**	**12**	**N/a**	
ALT	**7-56**	**18**	**N/a**	

Amylase	**0-137**	**N/a**	**N/a**	
Lipase	**12-70**	**N/a**	**N/a**	
Lactic Acid	**0.5-1**	**N/a**	**N/a**	
Troponin	**0.00-0.05 ng/mL**	**N/a**	**N/a**	
CK-MB	**5-25**	**N/a**	**N/a**	
Total CK	**22-198**	**N/a**	**N/a**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR		**N/a**	**N/a**	
PT		**N/a**	**N/a**	
PTT	**30-40 sec**	**34.7**	**N/a**	
D-Dimer		**N/a**	**N/a**	
BNP		**N/a**	**N/a**	
HDL		**N/a**	**N/a**	
LDL		**N/a**	**N/a**	
Cholesterol		**N/a**	**N/a**	
Triglycerides		**N/a**	**N/a**	
Hgb A1c		**N/a**	**N/a**	
TSH		**N/a**	**N/a**	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
Color & Clarity		**N/a**	**N/a**	
pH		**N/a**	**N/a**	
Specific Gravity		**N/a**	**N/a**	
Glucose		**N/a**	**N/a**	
Protein		**N/a**	**N/a**	
Ketones		**N/a**	**N/a**	
WBC		**N/a**	**N/a**	
RBC		**N/a**	**N/a**	
Leukoesterase		**N/a**	**N/a**	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH		**N/a**	**N/a**	
PaO2		**N/a**	**N/a**	
PaCO2		**N/a**	**N/a**	
HCO3		**N/a**	**N/a**	
SaO2		**N/a**	**N/a**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal	Value on	Today's	Explanation of Findings

	Range	Admission	Value	
Urine Culture		**N/a**	**N/a**	
Blood Culture		**N/a**	**N/a**	
Sputum Culture		**N/a**	**N/a**	
Stool Culture		**N/a**	**N/a**	

Lab Correlations Reference (APA):

Capriotti, T., Frizzell, J., (2016), *Pathophysiology Introductory concepts and clinical perspectives*. Philadelphia, PA, F.A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points): MRI

Diagnostic Test Correlation (5 points): Contribute to stoke diagnosis. The MRI showed acute right paramedian pontine which caused the stroke.

Diagnostic Test Reference (APA):

Stroke - diagnosis and treatment - mayo clinic. (2020, August 8). Retrieved September 19, 2020, from https://www.mayoclinic.org/diseases-conditions/stroke/diagnosis-treatment/drc-20350119

Current Medications (10 points, 1 point per completed med)
10 different medications must be completed

Home Medications (5 required)

Brand/Generic	Bupropion (budeprion)	Losartan (Cozaar)	Sennosides (Senokot)	Amantadine HCl (Gocovir)	Cyclobenzaprine

					(Amrix)
Dose	75 mg	100 mg	8.6 mg	100 mg	5-10 mg
Frequency	BID	Daily	Daily	BID	Daily at bedtime
Route	PO	PO	PO	PO	PO
Classification	Nicotine dependence	Angiotensin receptor blockers	Laxative	Dystonia's/ Parkinson's disease, flu	Fibromyalgia/ muscles relaxants
Mechanism of Action	Exact mechanism of action is smoking cessation or depression unknown; inhibits neuronal uptake of norepinephrine and dopamine.	Selectively antagonizes angiotensin II AT1 receptors	Increases peristalsis	Blocks viral particle uncoating and nucleic acid released into host cell, inhibiting viral replication; exact mechanism in Parkinson disease unknown; potentiates CNS dopaminergic responses	Exact mechanism of action unknown; potentiates norepinephrine and binds to serotonin receptors, reducing spasticity
Reason Client Taking	Client used to smoke and take this as alternative to smoking	The reason could be for either or both the hypertension and diabetic nephropathy	Client takes many medications of which can cause constipation	Client is immunocompromised	Client has periodic limb movement disorder
Contraindications (2)	Seizure disorder bulimia	Pregnancy Hypersensitivity	Hypersensitivity GI obstruction	Hypersensitivity Caution in renal impairment	Hypersensitivity Heart block
Side Effects/Adverse Reactions (2)	Suicidality Neuropsychiatric disorders	Diarrhea Fatigue	Nausea Abdominal distention	Hallucinations Dizziness	Drowsiness Headache
Nursing Considerations (2)	Monitor BP Do not confuse with busPIRone	Monitor BUN/Cr Monitor BP	Monitor electrolytes in long term use	Monitor Cr compared to baseline Check clients last	No routine tests recommended Do not

			Do not confuse with Soma	dermatologic examination	confuse with chlorpromazine
Key Nursing Assessment(s) Prior to Administration	Assess for suicidal thoughts Assess behavior in case of behavior changes after administration begins	Assess BP Compare BUN/Cr to baseline	Assess for when client had her last BM Assess for consistency of BM and frequency because it is not the goal to give diarrhea	Assess clients Cr Do not confuse with amiodarone	Check that medication is the correct name compared to the MAR Ask client their name and date of birth and tell them the medication is a muscle relaxant
Client Teaching needs (2)	Do not cut, crush, or chew extended release tablets Do not exceed 300mg per day and each dose should be 8 hours apart	Educate on s/s such as chest pain and asthenia This medication requires prescription but is not a controlled substance	Tell the client to be aware or last BM Educate that overuse of a laxative can cause constipation	This drug is not recommended for treatment of influenza A Tell the client to seek help with symptoms of CHF, cardiac arrest, and suicidality	Do not cut, crush, or chew this medication because it is extended release The nurse may hold the medication during the recover of an acute MI

Hospital Medications (5 required)

Brand/Generic	Aspirin	Benzocaine-menthol (cepacol Sore throat)	Calcium carbonate (Tums)	Clopidogrel (Plavix)	Gabapentin (Neurontin)

Dose	81 mg	1 lozenge	2 tablets (400 mg)	75 mg	400 mg
Frequency	Daily	PRN	Q6hrs	Daily	QID
Route	PO	PO	PO	PO	PO
Classification	antiplatelets	Local anesthetic	Antacids	Platelet aggregation inhibitors	anticonvulsants
Mechanism of Action	Non-selectively and irreversibly inhibits cyclooxygenase, reducing prostaglandin and thromboxane A2 synthesis, producing analgesic, anti-inflammatory, and antipyretic effects and reducing platelet aggregation	Combination; inhibits pain receptors in localized area for sore throat	Essential component and participant in physiologic systems and reactions	Irreversibly binds to P2Y12 adenosine diphosphate receptors, reducing platelet activation and aggregation	Exact mechanism of action unknown; blocks voltage-dependent calcium channels, modulating excitatory neurotransmitter release
Reason Client Taking	Thin the blood	Client may experience throat soreness from stoke	For upset stomach	Thin the blood	Diabetic neuropathy
Contraindications (2)	Hypersensitivity Aspirin triad	Hypersensitivity Caution in asthma and COPD	Hypersensitivity Hypercalcemia	Hypersensitivity Active bleeding	Hypersensitivity Caution in depressior
Side Effects/Adverse Reactions (2)	Dyspepsia Nausea	Erythema pain	Hypercalcemia Hypercalciuria	Bleeding Pruritus	Dizziness Somnolence
Nursing Considerations (2)	Toxic levels >300 mcg/mL Timing: 1-3hrs after dose	Assess for last administration Ask client if it was tolerable considering the facial drooping	Check Ca frequently if acute hypocalcemia Clinical check for hypocalcemia is trousseau sign	No routine tests recommended Do not confuse with Paxil	Monitor for s/s of depression Monitor for suicidalit
Key Nursing Assessment(s) Prior to	PT INR Cr at baseline	Assess pain level prior to administration	Assess calcium levels Ask the client if	PT INR	Compare Cr. to baseline Preform a neuro

Administration		Assess the client throat for redness or sores	she is experiencing any heart burn or stomach upset		assessment
Client Teaching needs (2)	No do not exceed 300 mcg/ml And take with food	Medication is available over the counter This is generally used for pain relief and may not resolve the cause of the underly pain	This medication is available over the counter without a prescription Can be taken with food	This medication can be given with aspirin between 75-325mg PO QID The Nurse may hold this medication for >5 days after a stoke pending surgery	The maximum dosing per day is 3600 mg/day If you are experiencir suicidal thoughts, you should contact your doctor.

Medications Reference (APA):

Jones & Bartlett Learning. (2019) *2019 Nurse's Drug Handbook, eighth edition.* Burlington, MA, Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Drowsy, when awake is alert and oriented x4 Well groomed, clam, recalls current president, name, and location, No apparent distress
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Warm, dry, clean, no rashes, or visible bruising, no open or closed wounds, no drains, moderate tenting in skin turgor Braden Score: 13

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Facial drooping of the left side Ears: moist, pink, and dry Eyes: moist, pink, dry Nose: midline, moist, pink, dry Teeth: missing some teeth on the bottom, top teeth dentin was good and clean Head and neck – midline PERLA
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Clear S1 and S2, no neck vein distention, normal sinus rhythm, peripheral pulses +1, capillary refill <3 seconds, no edema, no murmur
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	No use of accessory muscles Breath sounds clear in RUL and LUL Breath sounds diminished in RLL and LLL No ET tube
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐**	Home diet: regular Current: NPO 5’2” 67.1 kg Hypoactive bowel sounds in RUQ and RLQ Hyperactive bowel sounds in LUQ and LLQ Last BM was 09/14/2020 Reports no pain on palpation and no masses felt No distention, incisions, scars, drains, or wounds No ostomy No NG tube No feeding or PEG tube

Nasogastric: Y ☐ N ☐ **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	External urinary catheter Yellow and clear 2,800 mL output No reported pain on urination No dialysis No redness or irritation on inspection of genitals
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	Oriented x4 Strength unequal with weakness on the left side Unable to lift left arm or leg Needs assistance with ADL Fall Risk- yes Fall Score:17 Needs support to stand and walk - Client currently on bed rest until seen by physical therapy Yes- numbness and tingling on the left side
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW yes on right side not on Left PERLA Strength unequal because left side is weak with little to no ability to move Orientation x4 Mental status: alert Speech: slurred from facial drooping Sensory- impaired on lefts side No loss of consciousness Level of consciousness-awake
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and**	Daughter helps with care and at the bedside offers to help with communication No religion identified Owns no pets Developmental level appropriate for age Likes to relax and watch television on a normal day

available family support):	White DNR

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0819	73	152/83	18	97.5F Oral	92 Room air
1235	79	135/82	18	97.4F Oral	94 Room air

Vital Sign Trends/Correlation:

The blood pressure decreased because the blood pressure at 0819 was taken prior to medication administration. The blood pressure of 135/82 is an improvement of blood pressure due to antihypertensive medication being administered. All other vitals are stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0710	Numeric	Left side	5	Generalized	Pain medication administered
1235	Numeric	Left side	3	Generalized	Repositioning

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:**	18 G left antecubital peripheral IV, 9/13/2020, patent, clean, dry, intact. No signs of erythema, inflammation, or

Patency of IV: **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	drainage
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	None

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
580mL	2,800mL

Nursing Care

Summary of Care (2 points)

Overview of care: Client came in complaining of left sided weakness. She was had an MRI and was diagnosed with a stroke. Currently waiting for a bed at a rehabilitation center and is on bed rest while in the hospital until she sees physical therapy.

Procedures/testing done: Client had an MRI and was planning to have an Echo done with a bubble.

Complaints/Issues: Client complained of some pain and discomfort due to having difficulty in moving her left side.

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: currently NPO and bed rest

Physician notifications: Considering a possible IPR on Thursday

Future plans for patient: Speech therapy and planning for a possible IPR Thursday.

Discharge Planning (2 points)

Discharge location: inpatient rehabilitation, home

Home health needs (if applicable): speech therapy and physical therapy

Equipment needs (if applicable): still waiting on physical therapy to do an evaluation but possible options of walker or wheelchair.

Follow up plan: None currently

Education needs: Safety with new physical condition, stoke ischemic education for self-management.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Decreased functional ability related to weakness on the left side as evidenced by client expressing	The client has generalized weakness, numbness, tingling, and pain on the left side due to the stroke. She also had	**1.**Teach methods for turning and moving, using the stronger extremity to move the weaker extremity**.** **2.**Encourage the	The client seemed fatigues but agreed with the nurse to check position of the arm and leg of the left side before trying to use the right side to move like the nurse instructed. Some assistance was necessary

numbness and tingling with not being able to lift affected extremities on the left side.	difficulty talking due to facial drooping.	client to make a conscious attempt to look at extremities and check position before moving	from the nurse do to fatigue.
2. Aphasia related to cerebrovascular insult as evidence by facial drooping and difficulty talking.	The client has difficulty talking to the nurse, so the nurse had to lean in very close to understand and the facial drooping interfered with enunciation of her words.	1. Ask the client to repeat unclear words by speaking slowly in short phrases. If this is unsuccessful, as the client to use a different word or give a nonverbal cue. 2.Obtain referral to a speech therapist	The nurse asked the client to repeat their answer to their pain level and to stay it slowly. The nurse was able to understand the client said “five”. The client was pleased that the nurse understood what she said. After the nurse told the client that a referral was put in for speech therapy at the rehab center they were waiting to transfer to.
3. Potential for unilateral neglect related to ischemic damage affecting the right hemisphere related to left sided weakness.	The clients entire left side has weakness, numbness, and facial drooping of the left side. The client is at risk of not perceiving the affected side as apart of them as time goes on.	1. Periodically refer to the patient’s body parts of the left side and encourage the client to massage and look at the affected side. 2. Assess the client’s ability to recognize objects to the left of her visual midline, perceive body parts as her own, perceive pain, and	The nurse discussed the clients left side with every visit back to the client’s room and when assessing the client. The client stated she felts uncomfortable on her right side and wished to move. The nurse reminded the client to look over the left side and move it first. The client said she felt like her left side was harder to manage and that she started to forget to move her hand over. The nurse assisted with repositioning a pillow to make it easier for the client to see her left arm.

		temperature sensation.	
4. Potential for injury related to impaired sensory reception as evidence by numbness and tingling and minimal sensation.	The client did not have much sensation in her left side unless the nurse pressed very hard at the most distal part of her left arm.	1. Assess for type and degree of hemisphere injury the patient exhibits 2. Encourage making a conscious effort to scan the rest of the environment by turning head from side to side.	The client states she can feel some sensation to the touch but that she still feels numbness and tingling. The nurse did a pain assessment and found she had to place a light of pressure for a pain stimulation. The nurse tells the client that she should do her best to look around before doing anything physically when she off bed rest. Such as looking for clutter and watching for sharp corners to prevent injury.
5. Potential for aspiration related to stoke as evidence by left facial drooping and generalized left weakness.	The client is at risk for aspiration because if the left side of them of their epiglottis is affected with weakness or paralysis they could aspirate if it does not close all the way while swallowing	1. Instruct the client to sit up as much as possible when taking medications with water or apple sauce 2. Make a referral a swallow evaluation before allowing the client to order a meal.	The client allowed the nurse to elevate the bed to an upright sitting position while taking her medication with apple sauce. The nurse notified the client about the possibly risk of further aspiration when the client seemed to cough while drinking a sip of water. The nurse suggested a referral for a swallow evaluation before ordering food so the client could get food safe for her to eat.

Other References (APA):

Swearingen, P., (2019) *All-in-One Nursing Care Planning Resource*. Fifth edition. St. Louis, MI, Elsevier

Concept Map (20 Points):

Subjective Data

Client says she said a headache 2 days ago
CC: weakness on the left side

Nursing Diagnosis/Outcomes

Decreased functional ability related to weakness on the left side as evidenced by client expressing numbness and tingling with not being able to lift affected extremities on the left side. / The client seemed fatigues but agreed with the nurse to check position of the arm and leg of the left side before trying to use the right side to move like the nurse instructed. Some assistance was necessary from the nurse do to fatigue.
Aphasia related to cerebrovascular insult as evidence by facial drooping and difficulty talking. / The nurse asked the client to repeat their answer to their pain level and to stay it slowly. The nurse was able to understand the client said "five". The client was pleased that the nurse understood what she said. After the nurse told the client that a referral was put in her speech therapy at the rehab center they were waiting to transfer to.

Objective Data

Unequal strength with weakness unilaterally on the left side
Client alert and oriented x4
Clear S1 and S2
Diminished lung sounds in LLL and RLL

Patient Information

83 years old
Homemaker
White
Female
Admitted 09/13/2020

Nursing Interventions

Teach methods for turning and moving, using the stronger extremity to move the weaker extremity.

2.Encourage the client to make a conscious attempt to look at extremities and check position before moving
Ask the client to repeat unclear words by speaking slowly in short phrases. If this is unsuccessful, as the client to use a different word or give a nonverbal cue.

2.Obtain referral to a speech therapist