

N431 Care Plan #1

Lakeview College of Nursing

Jasmine Banks

N431 Care Plan

Demographics (3 points)

Date of Admission 9/24/20	Patient Initials RG	Age 75	Gender Male
Race/Ethnicity CAUCASIAN	Occupation RETIRED	Marital Status WIDOWED/SINGLE	Allergies NO KNOWN
Code Status FULL CODE	Height 175 cm	Weight 70.3 kg	

Medical History (5 Points)

Past Medical History: Stomach aneurysm, cataracts

Past Surgical History: Abdominal Aortic Aneurysm

Family History: None

Social History (tobacco/alcohol/drugs): Client states he smokes about 5 cigarettes a day. He stated he quit before coming into the hospital. Client states that he drinks alcohol about once a month.

Assistive Devices: None

Living Situation: By himself

Education Level: GED

Admission Assessment

Chief Complaint (2 points): Blurred vision

History of present Illness (10 points):

Client complains of having blurred vision. He states the blurred vision started on Thursday before he came into the hospital on September 24. He states that it affects both of his eyes. He stated that his blurred vision is continuous and consistent. He states that he can see better with the lights on. He also stated nothing makes his blurred vision worse. The client has not been given any treatment. The client states that his pain is a 0 out of 10.

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Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cerebrovascular Accident (Stroke)

Secondary Diagnosis (if applicable):

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

A cerebrovascular accident, also known as a stroke, is a loss of blood flow to a part of the brain (MedlinePlus, 2018). There are two different types of stroke, ischemic stroke, and hemorrhagic stroke (MedlinePlus, 2018). An ischemic stroke is caused by some type of blood clot that blocks a blood vessel in the brain (MedlinePlus, 2018). An ischemic stroke is the most common type of stroke (MedlinePlus, 2018). A hemorrhagic stroke is caused by a blood vessel breaking and bleeding into the brain (MedlinePlus, 2018).

Many risk factors could lead to a stroke. The risk factors for a stroke for high blood pressure, high cholesterol, heart disease, diabetes, obesity, sickle cell disease, tobacco use, alcohol use, physical inactivity, age, gender, and family history (Capriotti, Frizzell, 2016). My client is a male, uses tobacco and alcohol, and has high cholesterol which puts him at risk for having a stroke.

There are a few significant signs and symptoms that a client will experience if they have a stroke. The signs and symptoms associated with a stroke is facial droop, slurred speech, loss of gag reflex, vision loss in one or both eyes, hemiparesis, and loss of sensation (Capriotti, Frizzell, 2016). Some clients experience confusion, disorientation, and sleepiness (Capriotti, Frizzell, 2016). My client is not experiencing any facial droop, speech difficulty, or weakness, but he is experiencing blurred vision.

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Many diagnostic tests can be done to diagnose a stroke. The diagnostic tests are chest x-ray, electrocardiography, and blood work (Capriotti, Frizzell, 2016). Diagnostic tests of the brain include a CT scan, MRI, and an MRA scan (Capriotti, Frizzell, 2016). A CT scan should be performed as soon as the client gets to the facility (Capriotti, Frizzell, 2016). A national institute of health stroke scale may be done as well (Capriotti, Frizzell, 2016). My client underwent an EKG, CT scan of the brain, MRI of the brain, chest x-ray, echocardiogram, and an MRI of the neck.

When it comes to treatment for a stroke, a rapid diagnosis of the type of stroke is important (Capriotti, Frizzell, 2016). Treatment will begin with stabilizing the client to prevent any further brain injury (Capriotti, Frizzell, 2016). Maintaining a patent airway and stabilizing the client's blood pressure and cardiac rhythm is important (Capriotti, Frizzell, 2016). Regulating the client's blood glucose levels and body temperature is important as well (Capriotti, Frizzell, 2016). My client's blood pressure, cardiac rhythm, and blood glucose levels have all stabilized. He has a patent airway as well.

When it comes to a stroke, there are a few methods a client could do to prevent a stroke. Smoking cessation, stress management, physical activity, blood pressure and cholesterol management, and eating a heart-healthy diet are all ways to help prevent a stroke from occurring (MedlinePlus, 2018).

Pathophysiology References (2) (APA):

Capriotti, T., Frizzell, J. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. Philadelphia, F. A. Davis Company.

MedlinePlus. (2018, May 4). *Stroke | CVA | Cerebrovascular accident*.

MedlinePlus. https://medlineplus.gov/stroke.html#cat_78

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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	3.9-5	5.07	4.66	Red blood cells may increase when a client has a stroke (Cedars Sinai, 2019).
Hgb	12-15.5	16.4	14.6	The client may be dehydrated, or elevated hemoglobin may be due to the client smoking cigarettes (Capriotti, Frizzell, 2016).
Hct	35-45	47.6	43.4	The client may be dehydrated (Capriotti, Frizzell, 2016).
Platelets	140-400	293	296	Within normal range.
WBC	4-9	7.8	5.8	Within normal range.
Neutrophils	40-70	68.7	52.4	Within normal range.
Lymphocytes	10-20	19.7	31.3	Within normal range.
Monocytes	0-0.9	9.6	12.8	The client may have an infection (Capriotti, Frizzell, 2016,).
Eosinophils	0-0.5	0.9	2.9	The client may have an infection (Capriotti, Frizzell, 2016,).
Bands	<10%	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	135	137	Within normal range.
K+	3.5-5.1	4.1	4.6	Within normal range.

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Cl-	98-107	104	106	Within normal range.
CO2	22-29	18	25	
Glucose	70-99	82	86	Within normal range.
BUN	6-20	17	17	Within normal range.
Creatinine	0.5-1	1.19	1.07	The client may have kidney function problems, or the client could be dehydrated (Capriotti, Frizzell, 2016).
Albumin	3.5-5.2	4.2		Within normal range.
Calcium	8.4-10.5	9.1	8.4	Within normal range.
Mag	1.5-4.5	n/a	n/a	
Phosphate	2.5-4.5	n/a	n/a	
Bilirubin	0.3-1	n/a	n/a	
Alk Phos	35-105	68	n/a	Within normal range.
AST	0-32	10	n/a	Within normal range.
ALT	0-33	7	n/a	Within normal range.
Amylase	23-85	n/a	n/a	
Lipase	0-160	n/a	n/a	
Lactic Acid	<2	n/a	n/a	
Troponin	0-0.4	<0.010	n/a	
CK-MB	5-25	n/a	n/a	
Total CK	22-198	n/a	n/a	

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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	01.81-1.2	n/a	n/a	
PT	11.5-15	n/a	n/a	
PTT	23.5-37.5	n/a	n/a	
D-Dimer	<250	n/a	n/a	
BNP	<100	n/a	n/a	
HDL	>40	n/a	33	The client may consume a poor diet (Capriotti, Frizzell, 2016).
LDL	<100	n/a	156	The client may consume a poor diet (Capriotti, Frizzell, 2016).
Cholesterol	<200	n/a	225	High cholesterol could lead to atherosclerosis which could lead to a stroke (Cedars, 2019).
Triglycerides	<150	n/a	178	The client may consume a poor diet (Capriotti, Frizzell, 2016).
Hgb A1c	0-5.7	n/a	5.7	Within normal range.
TSH	0-5.5	n/a	2.97	Within normal range.

Urinalysis **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
Color & Clarity	Yellow/clear	Amber/hazy	n/a	The client may have a UTI (Capriotti, Frizzell, 2016).
pH	5-8	5	n/a	Within normal range.
Specific Gravity	1.005-1.034	1.029	n/a	Within normal range.
Glucose	Normal	Normal	n/a	Within normal range.
Protein	Negative	1+	n/a	The client may have a UTI (Capriotti, Frizzell, 2016).
Ketones	Negative	2+	n/a	The client may have a UTI (Capriotti, Frizzell, 2016).

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WBC	<=5	5	n/a	Within normal range.
RBC	0-3	13	n/a	The client may have a UTI (Capriotti, Frizzell, 2016).
Leukoesterase	Negative	Negative	n/a	Within normal range.

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	
PaO ₂		n/a	n/a	
PaCO ₂		n/a	n/a	
HCO ₃		n/a	n/a	
SaO ₂		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 Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	Negative	n/a	
Blood Culture	Negative	n/a	n/a	
Sputum Culture	Negative	n/a	n/a	
Stool Culture	Negative	n/a	n/a	

Lab Correlations Reference (APA):

Capriotti, T., Frizzell, J. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. Philadelphia, F. A. Davis Company.

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Cedars Sinai. (2019, January 24). *Stroke*. Cedars Sinai.

<https://www.cedars-sinai.org/health-library/diseases-and-conditions/s/stroke-1.html>

Lakeview College of Nursing. (2018). *Lakeview College of Nursing Lab Handout*. Lakeview College of Nursing.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): EKG, CT brain w/o contrast, chest x-ray, echocardiogram w/ contrast, MRI brain w/o contrast, MRI Angio neck w/ contrast, MRI Angio brain w/o contrast

Diagnostic Test Correlation (5 points):

The EKG, chest x-ray, echocardiograms are diagnostic tests used to rule out other problems that could mimic a stroke (Cedars Sinai, 2019). A CT scan is done to identify or exclude hemorrhage (Capriotti, Frizzell, 2016). It can also show a better visualization of ischemia (Capriotti, Frizzell, 2016). An MRI shows changes in the brain tissues that help to find and diagnose a stroke (Cedars Sinai, 2019).

Diagnostic Test Reference (APA):

Capriotti, T., Frizzell, J. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. Philadelphia, F. A. Davis Company.

Cedars Sinai. (2019, January 24). *Stroke*. Cedars Sinai.

<https://www.cedars-sinai.org/health-library/diseases-and-conditions/s/stroke-1.html>

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

Home Medications (5 required)

Brand/Generic	sodium chloride/	Lisinopril	carvedilol/	docusate	Polyethylene
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	Normal Saline		Coreg	sodium/ Colace	glycol 3350/ MiraLax
Dose	100 mL/hr	40 mg	3.25 mg	100 mg	17 g
Frequency	Continuous	daily	daily	daily	daily
Route	IV	PO	PO	PO	PO
Classification	Crystalloid	ACE inhibitor	Beta Blocker	stool softener	cathartics
Mechanism of Action	Restore fluid balance	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II.	Completely blocks beta- adrenergic receptors in the heart to decrease the influence of the sympatheti c nervous system on the tissues	Act as a detergent to facilitate admixing of fat and water in the stool.	Causes water to be retained with the stool.
Reason Client Taking	To treat possible dehydration.	To treat HTN.	To treat HTN.	Used to treat occasional constipatio n	To treat constipation.
Contraindicatio s (2)	Hepatic disease, edema, HTN	History of angioedema, hypersensiti vity to lisinopril	hypersensit ivity to Coreg, pulmonary edema	Fecal impaction, acute abdominal pain	Hypersensiti vity to drug,
Side Effects/Adverse Reactions (2)	Tachycardia, fever, shortness of breath, joint pain	HTN, HF, blurred vision, diarrhea	dizziness, drowsiness, blurred vision	Diarrhea, abdominal cramping, rash	Nausea, vomiting, abdominal pain
Nursing Considerations (2)	-Monitor VS -Monitor for adverse effects	-monitor client for adverse effects - Use cautiously in pt. with fluid volume deficit, HF, impaired	-Assess client's weight -monitor for adverse effects	-Should be taken with a full glass of water - Discontinue drug if rectal bleeding, cramping,	-Dissolve the powder in about 8 oz of water -assess for abdominal distention

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		renal failure, or sodium depletion.		nausea or vomiting occurs	
Key Nursing Assessment(s)/L ab(s) Prior to Administration	-Monitor I&Os -monitor for fluid volume overload	-monitor blood pressure frequently	-assess cardiopulm onary status	-Assess for abdominal distention -monitor bowel sounds	-Monitor the client's I&Os
Client Teaching needs (2)	-Notify nurse immediately of any burning or pain at the IV site -Educate client on adverse effects	-Take medication as prescribed -educate on reason for use and adverse effects of medication	-Do not take the herb betel palm -Report SOB, night cough, slow pulse, edema, rash, fever	-Encourage increase of fiber intake -Regular physical activity -Drink 6 to 8 glasses of water per day	-Refrigerate retains potency -Do not take longer than 2 weeks

Hospital Medications (5 required)

Brand/ Generic	Atorvastatin/ Lipitor	Enoxaparin/ Lovenox	Bayer/ Aspirin	Acetaminophen / Tylenol	Cyanocobala min/ vitamin B12
Dose	40 mg	40 mg	81 mg	650 mg	1000 mcg
Frequency	Daily bedtime	daily	daily	Every 4 hours PRN	Daily
Route	PO	SQ	PO	PO	PO
Classificat ion	HMG-CoA Reductase inhibitor, antihyperlipid emic	Antithrombotic	NSAID	Antipyretic, nonopioid analgesic	Water-soluble vitamin
Mechanis m of Action	Reduces plasma cholesterol and lipoprotein	Binds with antithrombin III, enoxaparin rapidly binds with and	Acts on the heat- regulating center in the hypothalamus	Acts directly on the temperature -regulating center in the hypothalamus	Increases vitamin B12 levels

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	levels.	inactivates clotting factors	and cause peripheral vasodilation, diaphoresis, and heat loss.	by inhibiting synthesis of prostaglandin E2.	
Reason Client Taking	To lower cholesterol.	To prevent DVT. To prevent ischemic complications	To prevent blood clots.	To reduce fever.	Client's b12 level is low.
Contraindications (2)	pregnancy, lactation, hypersensitivity to drug	Hypersensitivity to drug or its components, active major bleeding	Hypersensitivity to aspirin, alcoholism	Hypersensitivity to drug or its components, severe hepatic impairment	hypersensitivity to drug,
Side Effects/Adverse Reactions (2)	nausea, diarrhea, constipation	Vomiting, nausea, headache, fever	Hives, shock, confusion	HTN, headache, fever, agitation	hypokalemia, anaphylactic shock
Nursing Considerations (2)	-if severe muscle symptoms, fatigue, or cola-colored urine occurs, hold medication and notify provider -monitor liver function tests	-Do NOT give IM injection -keep protamine sulfate close in case of overdose.	-Ask about tinnitus -Don't crush timed-release or controlled release tablet unless directed	-monitor renal function -ensure daily dose does not exceed daily limits	-administering with food increases absorption -mixing the vitamin with fruit juice is okay
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Expect live function tests before therapy starts and after	-Monitor for overdose and adverse effects.	-Monitor client's coagulation studies	-monitor liver function tests before and during	-monitor electrolyte labs (especially potassium)
Client Teaching needs (2)	-Take medication as prescribed. -educate client on reasoning for	-Educate on adverse effects from the medication -notify provider if	-keep out of reach of children -notify provider if allergic	-Take medication exactly as prescribed -Educate on what the	-what dietary sources contain vitamin B12 -take prescribed

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	taking medication and adverse effects	bruising, dizziness, loss of consciousness, or bloody stool occurs	reaction occurs or if pain gets worse	medication is used for and the adverse effects to monitor for	vitamins as directed and for the appropriate time.
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Medications Reference (APA):

Jones & Bartlett Learning (2019). *2019 Nurse's Drug Handbook*. ed. 18

RxList. (2020). *Drugs A-Z list*. RxList. https://www.rxlist.com/drugs/alpha_a.htm
Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:	Alert and awake. A/Ox4 No acute distress Well-groomed
INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:	Pink Dry Warm Loose No No No 23 No
HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:	Normocephalic; normal ROM Normal; TM pearly grey bilateral, non-tender PERLA, EOMI, convergence Clear, intact, no mucus Good
CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill:	Normal sinus rhythm; S1, S2 heard; no murmur or gallop auscultated 3+ radial/brachial bilateral; 3+ dorsalis pedis bilateral <3 seconds

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Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:	No No
RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character	No Clear lung sounds in all lobes, bilaterally, anterior and posterior
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 <input type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/> Type:	Regular Regular; no specific diet/restrictions 175 cm 70.3 kg Active in all lobes 9/28/2020 Soft; no tenderness, masses, or pain upon palpation No No No No No No No No No No
GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size:	N/A N/A N/A No No N/A No
MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status:	Active ROM None Equal; bilateral No Yes 45

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Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/>	Yes
NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:	Yes Yes Yes A/Ox4 Aware and alert Clear; appropriate Equal; bilateral Awake, aware, and alert.
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 available family support):	Client states that he doesn't really feel like he has stress. Client states he doesn't have any coping mechanisms. Appropriate Christian; Client states he lives by the bible. Client states he has 3 children in Mattoon and a few more children that live in Georgia.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0803	76	104/69	16	36.8	92
1102	69	122/76	16	36.6	96

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	0-10	n/a	0	n/a	Continuously monitor client for pain
1017	0-10	Head	3	dull	Administer

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					client PRN Tylenol
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IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Left forearm
Date on IV:	9/27
Patency of IV:	Dry, intact, clean
Signs of erythema, drainage, etc.:	No erythema, drainage, or swelling.
IV dressing assessment:	Transparent

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
120 (orally)	n/a

Nursing Care

Summary of Care (2 points)

Overview of care: Client was A/Ox4 and is able to verbalize what he needs. Client was cooperative and calm throughout the shift. Vital signs were obtained at 0803 and 1102. Pain assessments were done twice throughout the shift as well. I administered the client their prescribed medication. PT came to work with my client around 0830. He had to walk around the floor, and he tolerated it well. I performed a head-to-toe assessment on the client around 1000. Around 1015 the client began to complain of a mild headache, so Tylenol was administered.

Procedures/testing done: No testing or procedures were done during my shift.

Complaints/Issues: None

Vital signs (stable/unstable): Stable except for the client's oxygen saturation at 0802. The client's oxygen saturation became stable around 1100.

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Tolerating diet, activity, etc.: Regular

Physician notifications: N/A

Future plans for patient: N/A

Discharge Planning (2 points)

Discharge location: It is unsure where the client will be discharged.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan:

Education needs: Client needs to be educated on the importance of compliance. He needs to be educated on strokes, such as their causes and manifestations. He needs to be educated on his vision changes.

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. Ineffective tissue perfusion related to a stroke as evidenced by client’s O2 saturation at 92%.	The client has a O2 saturation of 92%.	1. Monitor the client’s vital signs and neurological status frequently 2. Evaluate the client’s respirations, pupils, speech, and heart rhythm.	The client’s vital signs stable with regular respirations, and heart rhythm. The pupils, vision, and speech are not affected. The client’s O2 saturation is 95% or more.
2. Risk for Injury related to blurred vision as evidenced by	The client states he is having a hard time with the	1. Use a gait belt to transfer client from the bed to the chair.	The client regains his peripheral vision. The client’s blurred vision

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client stating he does not have peripheral vision.	blurred vision from the stroke. He no longer has peripheral vision either which makes The client is also on Lovenox which puts him at risk for bleeding as well	Use the gait belt to help client ambulate. 2. Place all of the things the client needs in his field of view and within reach.	improves or restores to normal.
3. Ineffective coping related to new vision changes as evidenced by the client stating he doesn't have any coping mechanisms and non-compliance history.	The client has new blurred vision that he is dealing with, but he states he has no coping mechanisms to deal with this new situation. The client stated that he doesn't understand why he had a stroke.	1. Teach the client some non-pharmacological coping methods such as deep breathing, imagery, and massage. 2. Encourage the client to express when their feeling stressed or overwhelmed.	The client is able to express when they are feeling stressed. The client verbalizes and demonstrates different ways to deal his stress. The client is able to verbalize things that stress him out.
4. Need for health teaching related to unfamiliarity as evidenced by client stating he doesn't understand why he had a stroke and non-compliance history.	Client states that he doesn't understand why he had the stroke and has a history of non-compliance.	1. Educate the client on lifestyle changes such as smoking cessation 2. Educate the client on importance of compliance and how it will benefit his health.	The client verbalizes accurate knowledge of modifiable risk factors, signs and symptoms, and the importance of medication and appointment compliance.

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health. St. Louis, MO: Elsevier.

Concept Map (20 Points):



