N431 Care Plan # 1 REDO

Lakeview College of Nursing

Kimberly Bachman

Demographics (3 points)

Date of Admission 3/17/20	Patient Initials OB	Age 60 y/o	Gender M
Race/Ethnicity Caucasian	Occupation Truck driver	Marital Status Divorced	Allergies Sulfa drugs
Code Status Full code	Height 5’ 10” or 177 cm	Weight 220 lbs or 100 kg	

Medical History (5 Points)

Past Medical History: Hypertension, Hypercholesterolemia, Type 2 Diabetes Mellitus that is uncontrolled, Obesity with a BMI of 31.6

Past Surgical History: Colonoscopy in 2018

Family History:

Mother-Diabetes

Father-Myocardial Infarction after a CABG surgery

Brother-Obesity

Sister-Breast cancer s/p mastectomy

Social History (tobacco/alcohol/drugs): 1 pack/day smoker for 40 years and denies alcohol consumption, denies drug use

Assistive Devices: Required no use of assistive devices prior to diagnosis at home

Living Situation: Lives at home alone when not on the road with his current truck driving career

Education Level: GED but no other education noted

Admission Assessment

Chief Complaint (2 points): Acute right sided weakness and facial droop

History of present Illness (10 points):

A sixty-year-old male presents to the Emergency Department for sudden acute right-sided weakness with facial drooping while at home. He isn't able to speak clearly and cannot make complete facial expressions. No nausea, vomiting, or other concerns noted. The client had a Computerized Tomography to check for acute bleeding, which was negative. Following a bolus of 0.9 mg tissue Plasminogen Activator, he received a drip of 81 mg/hour. The client was held in the Emergency department for a full 24 hours due to Intensive Care Unit hospital beds' unavailability. His speech is becoming clearer after the tissue Plasminogen Activator bolus; he can make expressions and lift his right hand without pain slowly. He was admitted to the neurological unit for continued evaluation under the care of Dr. Farquad.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Ischemic Stroke

Secondary Diagnosis (if applicable): N/A

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

An ischemic stroke is a cerebrovascular incident where there is a blockage of blood flow to the brain. An ischemic stroke accounts for close to 87% of all strokes apart from a hemorrhagic stroke or transient ischemic attacks (*Ischemic Stroke*, 2017). Brain damage can happen when the blood flow is blocked; therefore, the brain is not receiving oxygen, so brain damage or death can occur (*Ischemic Stroke*, 2017). There are multiple signs and symptoms such as weakness, numbness, tingling or paralysis of extremities, which can be on one or even both sides. The client may have vision problems such as blindness or double vision. Loss of coordination, confusion, and drooping of the face on one side also are

prevalent with an ischemic stroke (Ischemic Stroke, 2017). For this client, these symptoms occurred besides vision problems when described by himself and upon observation and results. This client showed some slight difficulty in the ability to form words correctly by slurring. It was determined by the swallow test that J.S. verified he is able to swallow his pills and food without any problems. Due to this test the physician put him on a consistent-carbohydrate diet to help with Type 2 Diabetes Mellitus and Hypercholesterolemia. From personal knowledge, some risk factors for clients having a stroke would be high blood pressure, heart disease, smoking, Diabetes Mellitus, lack of physical activity, etc.

The client has uncontrolled Type 2 Diabetes Mellitus, hypertension, and hypercholesterolemia, which are most illnesses that could contribute to the diagnosis. Type 2 Diabetes Mellitus can cause an ischemic stroke by the leftover sugar in the blood that the insulin doesn't take care of; this makes it build up in the vessels forming clots or fat deposits (waxy) sticking to their walls (*Ischemic Strokes(Clots)*, 2020). Hypertension can cause an ischemic stroke by the constant high pressure on the vessels narrowing and becoming damaged. When the vessels become damaged, they rupture or leak, which can block blood flow. Hypercholesterolemia happens by increasing cholesterol produced by the liver and dietary intake (Libr & Says, 2010). Some foods high in cholesterol are poultry, dairy, egg yolk, fish, meat, etc., foods rich in saturated fat and trans fat, which trigger the liver to make cholesterol (Libr & Says, 2010). This client could be eating these high cholesterol foods, and being that he is obese can explain the lack of activity/exercise helping to stay healthier. These causes can increase cholesterol in the bloodstream and clog the vessels partially or completely restricting oxygen, causing an ischemic stroke (*Ischemic Strokes(Clots)*, 2020).

Pathophysiology References (2) (APA):

***Ischemic strokes(Clots)*. (2020). Www.Stroke.Org. https://www.stroke.org/en/about-stroke/types-of-stroke/ischemic-stroke-clots**

***Ischemic stroke: Symptoms, treatment, recovery, and more*. (2017, September 22). Healthline. https://www.healthline.com/health/stroke/cerebral-ischemia**

Libr, V., & Says, A. (2010, February 18). *What is Hypercholesterolemia?* News-Medical.Net. https://www.news-medical.net/health/What-is-Hypercholesterolemia.aspx

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	3.80-5.30	N/A	N/A	
Hgb	12-15.8	N/A	15.3	
Hct	26-47%	N/A	47	
Platelets	140-440	N/A	143	
WBC	4-12	N/A	6.3	
Neutrophils	47-73%	N/A	N/A	
Lymphocytes	18-42%	N/A	N/A	
Monocytes	4-12%	N/A	N/A	
Eosinophils	0.0-5.0%	N/A	N/A	
Bands	0.0-5.0%	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-	133-144	N/A	139	
K+	3.5-5.1	N/A	3.6	
Cl-	98-107	N/A	106	
CO2	21-31	N/A	N/A	
Glucose	70-99	N/A	147	The body isn't able to produce enough insulin due to a dysfunction with the pancreas (Capricott, 2016). This client has uncontrolled DM Type 2
BUN	7-25	N/A	15	
Creatinine	0.50-1.20	N/A	0.9	
Albumin	3.5-5.7	N/A	N/A	
Hgb A1C	<5.7%	N/A	9.4	A test that can provide an average percentage of hemoglobin in the blood of about 3 months (Capricott, 2016). This client has uncontrolled DM Type 2
Calcium	8.6-10.3	N/A	N/A	
Mag	1.6-2.6	N/A	N/A	
Phosphate	3.4-4.5	N/A	N/A	
Bilirubin	0.0-1.2	N/A	N/A	
Alk Phos	34-104	N/A	N/A	
AST	13-39	N/A	N/A	

ALT	**7-52**	**N/A**	**N/A**	
Amylase	**30-110**	**N/A**	**N/A**	
Lipase	**0-59**	**N/A**	**N/A**	
Lactic Acid	**0.36-1.25**	**N/A**	**N/A**	
Troponin	**0-0.4**	**N/A**	**N/A**	
CK-MB	**3-5%**	**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	**0.8-1.1**	**N/A**	**1.03**	
PT	**11-13.5 sec**	**N/A**	**11.3**	
PTT	**25-35 sec**	**N/A**	**33.6**	
D-Dimer	**<250 ng/mL or <0.4 mcg/ mL**	**N/A**	**N/A**	
BNP	**<125 pg/mL**	**N/A**	**N/A**	
HDL	**40 mg/dL or higher**	**N/A**	**N/A**	
LDL	**<100 mg/dL**	**N/A**	**N/A**	
Cholesterol	**125-200 mg/ dL**	**N/A**	**N/A**	
Triglycerides	**<150 mg/dL**	**N/A**	**N/A**	
TSH	**0.5-5.0 mIU/ L**	**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 Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Clear and yellow	N/A	N/A	
pH	5.0-9.0	N/A	N/A	
Specific Gravity	1.003-1.030	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	7.35-7.45	N/A	N/A	
PaO2	80-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-28	N/A	N/A	
SaO2	94-100%	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):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Diagnostics

Chest X-ray was ordered to rule out abnormalities within the heart such as
The results were negative for any acute abnormalities. Cardiac silhouette is within normal limits.

CT head w/o contrast was ordered to rule out acute bleeding.
The results were consistent with no acute intracranial hemorrhage, mass, mass effect, or mid-line shift is seen. The ventricles are symmetrical. There is no convincing evidence of an acute territorial infarction.

EKG was ordered to check for abnormalities in the heart rhythm.
The results shown an ST without ectopy.

Diagnostic Test Correlation (5 points): See above

Diagnostic Test Reference (APA):

Pagana, K. D., & Pagana, T. J. (2014). Mosby's manual of diagnostic and laboratory tests. St. Louis, MO: Elsevier Mosby.

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

Home Medications (5 required)

Brand/Generic	**Lisinopril (Zestril)**	**Atorvastatin (Lipitor)**	**Glucophage (Metformin)**	**Neurontin (Gabapentin)**	**Insulin lispro (Novolog)**
Dose	**10 mg**	**40 mg**	**250 mg**	**600 mg**	**100 U**
Frequency	**BID**	**QD**	**BID**	**TID**	**Before meals**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Antihypertensive**	**Anti-hyperlipidemic**	**Antidiabetics**	**Anticonvulsant**	**Rapid acting insulin**
Mechanism of Action	**Lowers blood pressure by blocking conversion of angiotensin 1 to angiotensin 2**	**Reduces plasm cholesterol and lipoprotein levels**	**Helps control blood sugar levels**	**Prevent neuropathic pain**	**Lowers blood glucose levels**
Reason Client Taking	**HTN**	**Reduces amount of cholesterol made by the liver**	**Type 2 DM/ hypercholesterolemia**	**No reason just filled in for 10 meds**	**Lower blood glucose due to Type 2 DM**
Contraindications (2)	**Can cause renal issues, do not take, do not take if having hypotensive episodes**	**Active hepatic disease, breastfeeding**	**Do not take if client has severe kidney disease, Do not take if client has diabetic ketoacidosis**	**DO not take if diagnosis of respiratory illnesses such as COPD, do not take if diagnosis of mental illness**	**DO not take if experiencing hypoglycemia, do not take if client has peripheral edema or weight gain**

Side Effects/Adverse Reactions (2)	**Dizziness, hypotension, cough**	**Amnesia, hyperkinesia**	**Nausea, vomiting, diarrhea**	**Ataxia, fatigue, diplopia, aggressive behavior, cough**	**Hypokalemia, hypoglycemia**
Nursing Considerations (2)	**Watch for signs and symptoms of CHF, watch for signs of impaired renal function**	**Use cautiously with alcohol consumption, expect to measure lipid levels frequently**	**Check with provider if client needs to stop taking med before an US/CT scan, know this med does not treat Type 1 DM**	**DO not take if breastfeeding, Assess orientation**	**Administer 5-10 min before meals, rotate injection sites**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor blood pressure**	**Cholesterol**	**Blood glucose**	**Assess behavior**	**Blood glucose, HgbA1C**
Client Teaching needs (2)	**Teach to monitor blood pressure, explain what symptoms to help know when to check blood pressure**	**Take at the same time each day, do not break tablet**	**Client may develop lactic acidosis so monitor for this, Call the doctor if having trouble breathing or stomach pain**	**Monitor for signs and symptoms of toxicity, call provider if having slow breathing**	**Administer 5-10 min before meals, rotate injection sites**

Hospital Medications (5 required)

Brand/Generic	**hydrocodone-acetaminophen (Norco)**	**Clopidrogel (Plavix)**	**Metoprolol (Lopressor)**	**Ondansetron (Zofran)**	**Acetaminophen (Tylenol)**

Dose	**325 mg**	**75 mg**	**50 mg**	**4 mg**	**650 mg**
Frequency	**Q4H PRN**	**QD**	**BID**	**Q6H PRN**	**Q6H PRN**
Route	**Oral**	**PO**	**PO**	**Sublingual**	**PO**
Classification	**opioid**	**antiplatelet**	**Beta blocker**	**Serotonin Antagonist Antiemetic**	**Nonopioid analgesic**
Mechanism of Action	**binds to and activates the mu-opioid receptor in the central nervous system**	**Treats symptoms of stroke, blood clot, or heart problems**	**Relaxes blood vessels and slows heart rate to improve blood flow and decrease blood pressure**	**Reduces communication to vomiting center in the brain to decrease nausea.**	**Decrease pain/fever**
Reason Client Taking	**pain management**	**Prevents future clots from forming potentially causing another stroke**	**Decrease blood pressure**	**1st line for Nausea**	**Mild pain/more severe pain**
Contraindications (2)	**asthma, blockage in stomach or intestines**	**Do not take with metoprolol due to reducing the ability of effectiveness, Do not use with warfarin administration**	**Do not take medication if blood sugar is low, do not take with pulmonary edema**	**Anaphylaxis. DO not take if taking apomorphine which is a drug for Parkinson's disease.**	**Hypersensitivity, severe hepatic impairment**
Side Effects/Adverse Reactions (2)	**noisy breathing, confusion**	**Bleeding, thrombotic thrombocytopenic**	**Bradycardia, HF, pulmonary edema,**	**Constipations, dizzy, flushing, fatigue, headache**	**Hepatotoxicity, severe renal impairment**

		purpura, easy bruising	**blurred vision**		
Nursing Considerations (2)	**avoid with breastfeeding, do not crush, break, or open pill**	**Usually used after a loading dose,**	**Hold if HR less than 60**	**Use in prevention of postoperative nausea/vomiting. Monitor for anaphylaxis**	**Monitor liver function studies. Monitor renal function studies.**
Key Nursing Assessment(s) /Lab(s) Prior to Administration	**renal function tests, liver function tests**	**Platelets, PT, PTT, INR**	**Blood pressure**	**Assess GI symptoms**	**Pain level**
Client Teaching needs (2)	**know adverse effects, may need to take with laxative**	**Monitor for bleeding symptoms such as bruising, do not take if prescribed warfarin**	**Monitor blood pressure, monitor for signs and symptoms of hypotension**	**Put underneath tongue to dissolve, do not swallow whole**	**DO not drink alcohol while on medication, do not take if breastfeeding**

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**A/O x3 to person/place/situation** **No apparent distress** **Overall well groomed** **Weak appearance**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:N/A**	**Pale white skin r/t ethnic background** **Moist/clean/intact** **Temp is warm at 37.0 C** **No tenting, good skin turgor** **No rashes, bruises, or wounds** **Braden score: 20**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is normocephalic, no lesions/lacerations** **No redness, no drainage, no swelling** **No ocular drainage/redness/irritation** **No redness or drainage** **Intact, oral mucosa pink/moist** **Normal dentition** .
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: N/A**	.**no abnormalities noted** **S1/S2 heard** **No murmurs, no clicks, no gallops** **NSR** **+2 all pulses bilaterally felt :apical, radial, carotid, brachial, femoral, popliteal, posterior tibial, and dorsalis pedis** **<3 sec cap refill** **No neck vein distension** **No edema noted**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**No accessory muscle use** **Breath sounds clear/equal bilaterally in all lung fields**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:**	**Normal diet no restrictions at home** **Carb consistent ordered** **5' 10"** **220 lbs BMI: 31.6**

Weight: **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Last BM was 12/13/20** **Bowel sounds are heard in all four quadrants** **No pain/masses on abdomen are palpable** **No abnormalities noted** **No abdominal distension** **No incisions no scars, drains, wounds, ostomy, or NG** **No feeding tubes or PEG tubes**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**urine yellow/clear, 800 ml** **no odor, no dysuria, no dialysis, no abnormalities noted, no catheter**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:5/5 on left side extremities/body** **3/5 on right side extremities/body** **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☐**	**Appropriate for situation- A/O x3** **Needs wheelchair to adapt to situation** **ROM mild weakness on R side of body** **Independent ADL's** **Moves fairly easy w/mild weakness on R. side** **Fall Score: 45** **Slight Numbness, tingling, and sensation on right side of body present 3/5** **No numbness, tingling, or sensation on left side of body 5/5**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒**	**Right side of body has facial droop and mild weakness of 3/5 with tingling, and numbness** **Left side has no sensory deficits** **A/O x 3** **Appropriate for developmental stage (no**

Orientation: **Mental Status:** **Speech:** **Sensory:** **LOC:**	**deficits)**
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):**	**Divorced** **Truck driver** **Attends online Christian church every Sunday** **Developmental level is appropriate for 63 y/o adult living alone** **Uses relaxation techniques such as guided imagery and seeks out support from this nurse as coping methods**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**76**	**163/76**	**16**	**37.0**	**98% Rm air**
1100	**69**	**124/63**	**18**	**36.9**	**97% Rm air**

Vital Sign Trends: The vital signs taken during the clinical time allotted were stable and within normal limits. At 0700, his systolic B/P was slightly elevated but checking the usual range for this client, it was not worrisome because his blood pressure remains within that level. During our clinical time there weren't any vital sign values that caused concern.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**Numeric**	**Head**	**4/10**	**Generalized ache**	**Norco was given to ease pain**
1100	**Numeric**	**Head**	**1/10**	**Generalized ache**	**None**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **18 G** **18G** **Location of IV:** **left antecubital** **right antecubital** **Date on both IV: 12/13/20** **Patency of IV: Both flowing without difficulty , blood return was present, flushed with ease, no signs of infiltration noted such as leakage/coolness/redness/puffy/blanching/tenderness** **IV's are lock noted** **Signs of erythema, drainage, etc.: No signs of erythema, drainage, or swelling** **No infiltration or phlebitis noted** **IV dressing assessment: Clean/dry/intact**	**All on the left**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
ORAL: Water- 600 ml with breakfast **Sugar-free orange juice 120 ml with breakfast**	**Urine voided- 800 ml total within 4 hours** **Stool x1**

Nursing Care

Summary of Care (2 points)

Overview of care: Glucose monitoring ordered AC/HS and to call MD for Glucose >200. The client was unproblematic, ordered from the carb menu with BS taken before eating and insulin lispro was given to normalize levels of BS in the blood. Norco was given

for generalized pain around 0900 and he received all other medications on time. Client voided three times during clinical time.

Procedures/testing done: Client did not leave the floor for any procedures or testing

Complaints/Issues: The client did not have any complaints or issues today

Vital signs (stable/unstable): The clients VS were stable during clinical time and did not warrant concern.

Tolerating diet, activity, etc.: Tolerating the carb diet well and is able to maintain safety while ambulating. Occupational Therapy and Physical Therapy will help hopefully improve his activity.

Physician notifications: The client is to follow up with PCP and contact facility if any changes or worsening in his condition. Neurologist appointment needed 1 week after discharge.

Future plans for patient: 6 week follow up PCP for Hgb A1C, PT/OT referral

Discharge Planning (2 points)

Discharge location: The client lives at home where he lives alone

Home health needs (if applicable): The client does not require home health needs

Equipment needs (if applicable): The client does not require any equipment needs

Follow up plan:

F/u with PCP in 6 weeks for A1C check considering admission level was 9.4

Neurologist appointment needed 1 week from discharge

Education needs: Right now, the client only needs education for his neurologist consultation and the follow-up appointment for his HgbA1C with his PCP in 6 weeks. The client needs to be retaught how to manage his blood sugar properly and efficiently to

improve his HgB A1C—teaching how to practice safe ambulation and importance of taking his time getting up and out of bed or chairs at home.

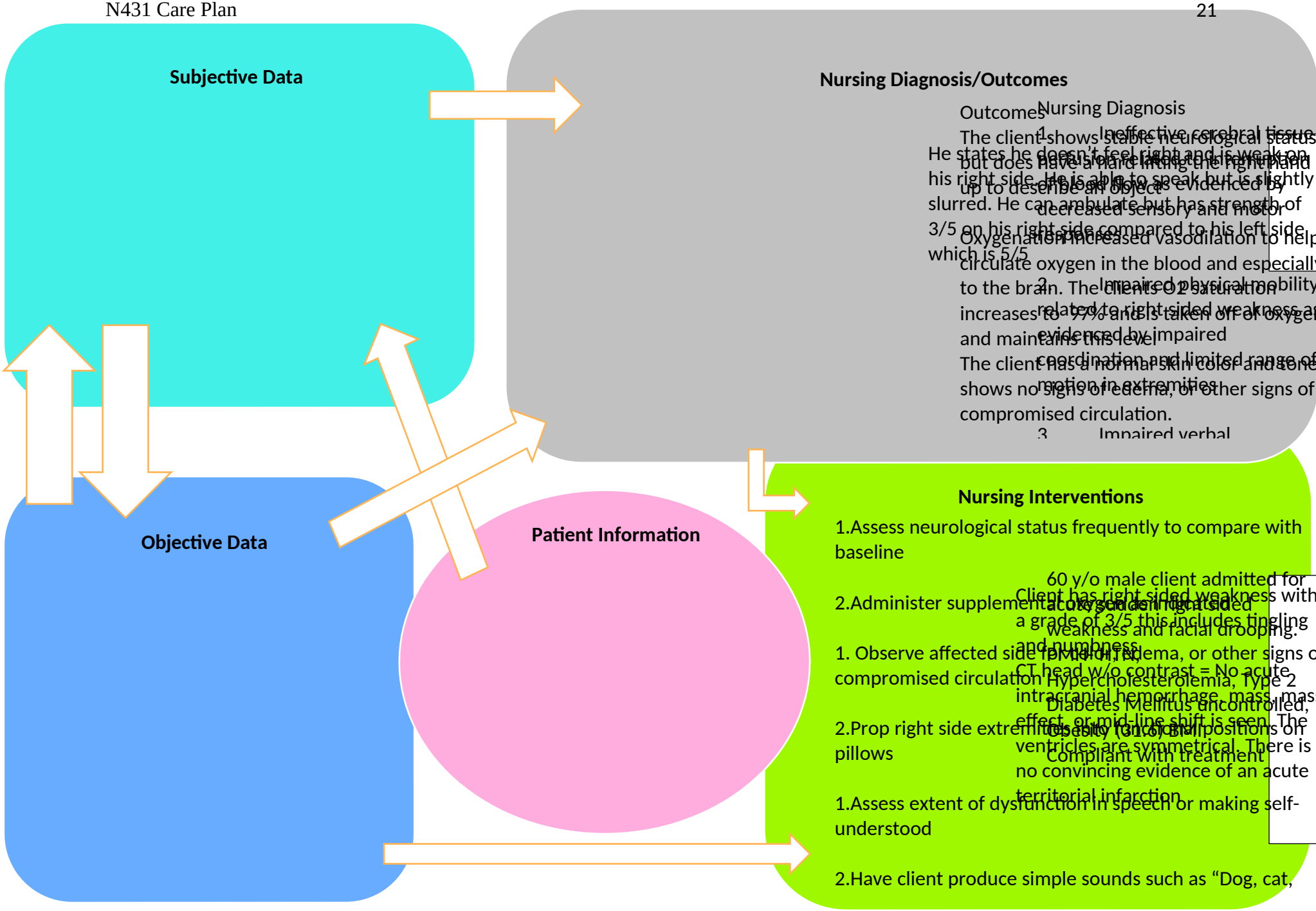
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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 cerebral tissue perfusion related to interruption of blood flow as evidenced by decreased sensory and motor responses	**Cerebral tissue perfusion is effected by blockage of blood flow/oxygen to the brain which causes an impairment in ability to function physically on one side and sensory issues.**	**1.Assess neurological status frequently to compare with baseline** **2.Administer supplemental oxygen as indicated**	**The client shows stable neurological status but does have a hard lifting the right hand up to describe an object** **Oxygenation increased vasodilation to help circulate oxygen in the blood and especially to the brain. The clients O2 saturation increases to 97% and is taken off of oxygen and maintains this level**
2. Impaired physical mobility related to right sided weakness as evidenced by impaired coordination and limited range of motion in extremities	**Impaired physical mobility is observed when there is damage to the brain that caused limping when**	**1. Observe affected side for color, edema, or other signs of compromised circulation**	**The client has a normal skin color and tone, shows no signs of edema, or other signs of compromised circulation.**

	walking and dysarthria	**2.Prop right side extremities into functional positions on pillows**	**Right sided extremities affected were on pillows to maintain a functional position.**
3. Impaired verbal communication related to impaired cerebral circulation, loss of facial tone/control, and generalized weakness as evidenced by slight slur when speaking	**Impaired verbal communication is a common side effect of brain damage due to inability to oxygenate the brain for a period of time and client will have slurred or garbled speech**	**1.Assess extent of dysfunction in speech or making self-understood** **2.Have client produce simple sounds such as "Dog, cat, etc."**	**The client demonstrates expressive aphasia which makes it difficult to speak words correctly.** **The client was able to produce the simple sounds once or twice with breaks in-between.**
4. Disturbed sensory perception related to altered sensory reception/transmission as evidenced by cues of numbness and tingling given by client	**Disturbed sensory perception is caused when oxygen is decreased to the brain and brain damage occurs leading to inability to attach words to objects**	**1. Evaluate visual deficits such as visual field, changes in depth perception, etc.** **2. Speak in calm, comforting, quiet voice, make sure to use simple sentences and maintain eye contact**	**The client wasn't able to have normal depth perception because he fell when trying to sit on wheelchair.** **The assessment of the client shows he is relaxed and able to understand the simple sentences.**

Other References (APA):

Concept Map (20 Points):


Subjective Data
He states he doesn't feel right and is weak on his right side. He is able to speak but is slightly slurred. He can ambulate but has strength of 3/5 on his right side compared to his left side which is 5/5
Objective Data
60 y/o male client admitted for acute cerebral infarction
Client has right sided weakness with a grade of 3/5 this includes tingling and numbness.
CT head w/o contrast = No acute intracranial hemorrhage, mass, mass effect, or mid-line shift is seen. The ventricles are symmetrical. There is no convincing evidence of an acute territorial infarction
Patient Information
Hx of HTN, Hyperlipidemia, or other signs of compromised circulation Hypercholesterolemia, Type 2 Diabetes Mellitus uncontrolled, Obesity (BMI 34), Compliant with treatment
Nursing Diagnosis/Outcomes
Outcomes
The client shows stable neurological status but does have a hard hitting the right hand up to describe an object
Oxygenation increased vasodilation to help circulate oxygen in the blood and especially to the brain. The clients O2 saturation increases to 97% and is taken off of oxygen and maintains this level
The client has a normal skin color and tone, shows no signs of edema, or other signs of compromised circulation.
Nursing Diagnosis
1 Ineffective cerebral tissue perfusion, related to decreased sensory and motor
2 Impaired physical mobility related to right-sided weakness as evidenced by impaired coordination and limited range of motion in extremities
3 Impaired verbal
Nursing Interventions
1.Assess neurological status frequently to compare with baseline
2.Administer supplemental oxygen as indicated
1. Observe affected side for edema, or other signs of compromised circulation
2.Prop right side extremities on pillows
1.Assess extent of dysfunction in speech or making self-understood
2.Have client produce simple sounds such as "Dog, cat,