N431 Care Plan #2

Lakeview College of Nursing

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Demographics

Date of Admission 5/28/21	**Patient Initials** P.C.	**Age** 88 years old (3/22/1933)	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired (former real estate agent and flower shop owner)	**Marital Status** Married; patient and husband share two children together (one son and one daughter)	**Allergies** Atorvastatin (high severity, 10/19/20), Crestor (high severity, 10/19/20), Propoxyphene (medium severity, reaction: vomiting, 3/17/14), and Hydrocodone acetaminophen (low severity, reaction: hives and rash, 7/2/2021)
Code Status Full	**Height** 5’4”	**Weight** 116 pounds (52.6 kg) BMI: 19.91	

Medical History

Past Medical History: Patient has a past medical history of supraventricular tachycardia, TIA, cellulitis of left lower leg, chronic foot ulcer, hyperlipemia, hypertension, MRSA, chronic reflux esophagitis, osteoarthritis, overactive bladder, urinary frequency (9/3/20), urinary infection (9/28/20), urge incontinence, stroke lacunar (2/20/20), acute cystitis without hematuria (9/3/20) and nocturia (9/3/20).

Past Surgical History: Patient has a past surgical history includes endoscopy of the colon (2016), foot surgery and wrist surgery.

Family History: Patient has a family history that includes hypertension with her mother. Patient denies any other medical conditions with her family.

Social History (tobacco/alcohol/drugs): Patient reports that she has never smoked. She has never used smokeless tobacco. She reports current alcohol use. Patient states she indulged in one or two glasses of wine a week. Patient stated she has done this for the pass 2-3 years. She reports that she does not use drugs.

Assistive Devices: Patient denies the use of hearing aids. Patient uses glasses. Patient states she uses them the most when reading her book or reading the newspaper. Patient denies the use of a walker, wheelchair or cane. Patient uses partial dentures for her lower teeth.

Living Situation: Patient lives with her husband in a one-story house in Danville Illinois. Patient stated she has resided in Danville Illinois for the past 40 years with her husband. Patient denies use of respiratory equipment at home. Patient has a private pay house cleaner that comes once a month to clean. Patient denies having any other in home or outside service in place at the time of this assessment. Patient has two children whom all live in Illinois within close proximity to her. Patient stated her daughter lives within an hour of her whereas her son lives within 3 hours from

her and visits often during the holidays and pre-COVID era. Patient stated she was previously independent with ADLs. Patient stated she does not drive but depends on her husband for transportation and sometimes her daughter when she is off. Patient states at home she has a shower chair and grab bars in her shoulder.

Education Level: Patient education extended to high school. Patient stated she graduated from high school. Patient stated she did not attend college and had no interest in doing so. Patient denies any learning barriers. Patient stated she enjoyed school and did well.

Admission Assessment

Chief Complaint: Left arm weakness

History of Present Illness: P.C. is an 88 year old female who was recently seen and admitted and discharged for a TIA. Patient presented to the hospital with complaints of left arm weakness which was resolved. Patient presented with left arm weakness which resulted in patient's husband lowering her to the floor at home because she became weak and "could not stand well" according to her husband. Patient stated her left arm felt weak and numb. Patient stated the onset of her TIA symptoms started early afternoon around noon. Patient stated the symptoms were in her left arms. Patient described the pain as being weak and numb. Patient denies any other associating factors. She did not have a headache, no fecal deficits or speech disturbance, no abdominal pain, no constipation or diarrhea. Patient stated nothing relieved the weakness or numbness. Patient denies the weakness or numbness radiating to any other body parts. Patient stated it just went away on its own. Patient represented to the hospital several times with TIA symptoms which were all resolved by the time she came to the hospital. R.C. stated before she came to the hospital but resolved when she was seen in the emergency room. A CT angio head

scan was done which was indictive of no acute hemorrhages or infarctions. Patient did have mild to moderate atherosclerosis in some of the vessel.

Primary Diagnosis

Primary Diagnosis on Admission: Transient Ischemic Attack (TIA)

Secondary Diagnosis: acute chronic renal failure, hypertension and hyperlipidemia

Pathophysiology of the Disease, APA format: Transient Ischemic Attack (TIA)

Transient Ischemic Attack (TIA) is another kind of ischemic injury of the brain. Many person refer to this as a "mini" stroke. A TIA is described as being "a disruption of cerebral circulation with neurological deficits that are reversible and last for less than 24 hours" (Capriotti, 2020). In a TIA, the body is able to naturally dissolves the clot that caused the ischemia (Panuganti et al., 2020). With a TIA, circulation returns and there is no permanent neurological injury if rapid assessment and early interventions are implemented. With this being said, a TIA is often a warning sign of future stroke. Individuals who are having a TIA may present with neurological symptoms that can last for several minutes to hours. A TIA often times results from an ischemic stroke in which the blood clots in the brain. The underlying cause of a TIA is "a buildup of cholesterol-containing fatty deposits called plaques (atherosclerosis) in an artery or one of its branches that supplies oxygen and nutrients to your brain" (Capriotti, 2020). The risk factors to a TIA are family history, age, male, prior TIA episodes and sick cell disease. Some of these manifestations could include numbness or muscle weakness which usually effects one side of the body, difficulty speaking or understanding speech, dizziness or loss of balance or double vision (Panuganti et al., 2020). Expected vital sign changes that occurs with a TIA is an elevation of the blood pressure and temperature due to the body's attempt to compensate. The diagnostic test used to identify a TIA is a CT scan of the head or an MRI to determine the

possible case of the TIA, check for damage of the brain as well as look for other disease processes such as a tumor (Panuganti et al., 2020). Upon admission, P.C. had a CT angio head scan done. The results displayed no acute hemorrhages or infarctions. Patient did have mild to moderate atherosclerosis in some of the vessel. Treatment for a TIA consist of medication therapy such as aspirin, anticoagulants like warfarin, antihypertensive to decrease the patient's risk of experiencing another TIA or stroke, and statin medication to reduce the risk of a stroke or another TIA. The last resort for a TIA is surgery. In some cases, an operation called a carotid endarterectomy may be recommended after having a TIA. This procedure involves removing part of the lining of the carotid arteries another with any blockage inside the arteries such as plaque from atherosclerosis (Panuganti et al., 2020). For this particular patient, aspirin was administered to her upon arrival to the emergency department. Aspirin is administered during episodes of stroke or TIA to prevent clothes and reduce the risk for the occurrence of another TIA or stroke.

Pathophysiology References:

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives 2nd Edition* (2nd ed., p. 562). Philadelphia: F A Davis.

Panuganti, K., Tadi, P., & Lui, F. (2020). *Transient Ischemic Attack*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK459143/

Laboratory Data

COMPLETE BLOOD COUNT

Lab	Normal Range	Admission Value 5/28/21	Today's Value 6/1/21	Reason for Abnormal Value
RED BLOOD CELLS (carry oxygen)	F: 4.2-5.4	**4.1**	N/A	There is a slight elevation of red blood cells in this patient's lab. The reasoning for a slight elevation for RBC in P.C.'s lab is due to her history of chronic renal disease. Chronic renal disease causes low hemoglobin because it results in the kidneys not being able to make enough erythropoietin. With low erythropoietin production, it causes the red blood cells you drop and anemia to drop overtime due to the kidneys failing and no longer making erythropoietin. However, with the patient's slight decrease in hemoglobin, this is not much of a concern at the moment but is definitely a lab that professional should closely monitor over time.
HEMOGLOBIN (oxygen-carrying protein in RBCs)	F: 12-15.5	13.8	N/A	
HEMATOCRIT (the proportion of RBCs to the fluid component, plasma in your blood)	F: 36-44%	41.1	N/A	
PLATELETS (help with blood clotting)	150,000-450,000	243	N/A	
WHITE BLOOD CELLS (fight infection)	4,000-10,000	9,000	N/A	
NEUTROPHILS (type of WBC that the bone marrow creates; travel into blood stream	40-60	**76.0**	N/A	The reason for a dramatic elevation in neutrophils in this patient's lab this because of her history of recurrent TIAs. In patients with strokes, it is common for their neutrophils to rise

and move to areas of infection and neutralize that area)				within the first few hours of its onset. After a TIA, neutrophils respond quickly to promote along with large infarct volume (Schäbitz & Minnerup, 2019).
LYMPHOCYTES (B cells: produce antibodies to attack bacteria T-cells: kill infected cells	20-40	**16.8**	N/A	Decreased lymphocytes is seen following a TIA mostly pronounced within 12 hours after stroke onset.
MONOCYTES (fight infection; help remove dead tissues; destroy cancer cells)	2-8	6.7	N/A	
EOSINOPHILS (participating in immediate allergic reactions)	0-4	0.2	N/A	
BANDS (immature form of neutrophils; produced in excess during infection to help fight disease)	3-7	N/A	N/A	This lab was not shown within the patient's cast.

Chemistry

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal

NA- (Control BP and blood volume; needed for muscle and nerves to work)	135-145	137	N/A	
K+ (helps your nerves to function and muscles to contract; heartbeat stay regular; move nutrients into cell and waste products out of cell)	3.5-5.0	4.0	N/A	
Cl- (helps keep the amount of fluid inside and outside of your cells in balance; maintain blood volume, BP and pH)	95-105	102	N/A	
CO2 (regulates the pH of blood, stimulates breathing, and influences the affinity hemoglobin has for oxygen)	23-30	28	N/A	
Glucose (for energy)	70-110	**146**	N/A	A reasoning for an increased glucose level could be stress from being hospitalization. Stress blocks your body from releasing insulin, and lets glucose pile up in your blood. If you're stressed for a long time, your sugar levels will keep building. Since this patient's blood sugar is slightly elevated or not too outside out normal range, it is likely due to stress. Elevated blood glucose is common in the early phases of a stroke as well. Over time, high blood sugar levels can damage the blood vessel.
BUN (measures the amount of nitrogen in your blood that comes from the waste	10-20	**29**	N/A	Had the patient's creatinine also been elevated along with the BUN, that would lead me to believe this is due to her history of chronic kidney failure. However, since her BUN is

product urea; indicates how well your kidney are working)				slightly elevated it could potentially be due to dehydration which is not uncommon in elderly patients. Dehydration is common due to their lack of thirst sensation with age. High BUN will result due to the lack of fluid volume to excrete waste products. I did not ask the patient about her intake of protein, however a diet low in protein can also cause an elevated BUN level as well as malnutrition. This patient's BMI is 19.91 which is considered to be within normal range, however on the lower end of normal. Within the patient's cart, it is document that she is supposed to avoid NSAIDs and IV dyes due to chronic kidney failure. So, although this patient's creatinine is within normal range, it is on the higher side of the normal range. So, this should be carefully monitor by professionals. If elevated along with BUN this is a good indicator that the patient's kidneys are functioning poorly and kidney's ability to remove urea from the blood has decreased.
CREATININE (to be filtered and eliminated in urine)	0.6-1.5	1.10	N/A	
ALBUMIN (helps keep fluid in your bloodstream so it doesn't leak into other tissues)	3.5-5.0	4.1	N/A	
CALCIUM (stored in bones and teeth; supports structure; carries massages between the brain and body parts)	8.5-10.0	9.5	N/A	
MAGNESIUM (required for energy production)	1.5-2.5	N/A	N/A	
PHOSPHATE (build and repair bones and teeth, help nerves function, and make muscles contract)	2.8-4.5	N/A	N/A	
BILIRUBIN (orange-yellow pigment that occurs normally when part	0.3-1.2	0.5	N/A	

of your red blood cells breaks down)				
ALK PHOS (mostly found in the liver, bones, kidneys, and digestive system. When the liver is damaged, ALP may leak into the bloodstream)	20-90	53	N/A	
AST Checks for liver damage	5-40	16	N/A	
ALT Test for liver cell damage	7-56	14	N/A	
Amylase Test for disease of the pancreas	30-110	N/A	N/A	
Lipase Helps your body digest fats; normal to have a small amount in body; protein that helps your body absorb fats (for pancreas)	0-160	N/A	N/A	
Lactic Acid Substance made by muscle tissue; high disrupt a person's acid pH balance; lactic acidosis caused by not enough oxygen in cells/ tissues	0.5-2.0	N/A	N/A	
Troponin	0-0.4	N/A	N/A	
CK-MB	5-25	N/A	N/A	
Total CK	22-198	N/A	N/A	

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Reason for Abnormal**
INR	0.8-1.1	1.0	N/A	

PT	11-13.5	12.9	N/A	
PTT	25-35	28	N/A	
D-Dimer	Negative	N/A	N/A	
BNP	Less than 100	N/A	N/A	
HDL	60	N/A	N/A	
LDL	Less than 100	N/A	N/A	
Cholesterol	Less than 200	N/A	N/A	
Triglycerides	Less than 150	N/A	N/A	
Hgb A1c	Below 5.7	5.7	N/A	
TSH	0.4-4	N/A	N/A	

Urinalysis

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Reason for Abnormal**
COLOR & CLARITY	Colorless-Yellow, Clear	N/A	N/A	This lab was now shown with in this patient's chart.
pH	6-8.0	N/A	N/A	
SPECIFIC GRAVITY (test compares the density of urine to the density of water; help determine how well your kidneys are diluting your urine)	1.005-1.030	N/A	N/A	
GLUCOSE	Negative	N/A	N/A	
PROTEIN	0-8	N/A	N/A	
KETONES (fuels for the body that are made when glucose is in short supply)	Negative	N/A	N/A	

WBC	0-4	N/A	N/A	
RBC	0-3	N/A	N/A	
LEUKOESTERASE	Negative	N/A	N/A	

Arterial Blood Gas

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	22-26	N/A	N/A	
SaO2	92-100	N/A	N/A	

Cultures

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
URINE CULTURE	Negative	N/A	N/A	This lab was now shown with in this patient's chart.
BLOOD CULTURE	Negative	N/A	N/A	This lab was now shown with in this patient's chart.
SPUTUM CULTURE	Negative	N/A	N/A	This lab was now shown with in this patient's chart.
STOOL CULTURE	Negative	N/A	N/A	This lab was now shown with in this patient's chart.

Lab Correlations Reference:

Kathleen Deska Pagana. (2020). *Mosby's Diagnostic And Laboratory Test Reference.* Elsevier Mosby.

Schäbitz, W.-R., & Minnerup, J. (2019). Neutrophils in Acute Stroke Pathophysiology. *Stroke*, *50*(3). https://doi.org/10.1161/strokeaha.118.024300

Diagnostic Imaging

All Other Diagnostic Tests:

1. Exam: CT Angio Head w/o Contrast

Indication: Patient has a history of recurrent TIAs. Patient presented with left arm weakness which resulted in patient's husband lowering her to the floor at home because she became weak and "could not stand well" according to her husband. Patient stated her left arm felt weak and numb. Patient stated the onset of her TIA symptoms started early afternoon around noon. Patient stated the symptoms were in her left arms.

Impression:

1. About 50% stenosis in the left A2 ACA segment.
2. Mild right intracranial vertical artery atherosclerosis with increase to 70% stenosis.
3. Atherosclerosis on the distal right P2 PCA.

Diagnostic Test Correlation: This exam was ordered for this patient due to her history of TIAs and the symptoms she presented with. A CT scan helps with identifying whether the stroke is hemorrhagic or ischemic. It shows bleeding in the brain or damage to the brain cells from a stroke or TIA (Yu & Coutts, 2018). This test also helps with showing other brain conditions that could potentially be causing the patient's symptoms.

2. Exam: EKG 12 Lead

Indication: TIA and history of supraventricular tachycardia

Impression: Normal sinus rhythm, baseline wander, left axis deviation, left ventricular hypertrophy with repolarization abnormality. No significant change was found.

Diagnostic Test Correlation: This exam was ordered for this patient due to her history of supraventricular tachycardia and TIA. EKG help show abnormal heart rhythms that can contribute to the cause of a TIA such as atrial fibrillation. EKGs overall help visualize the electrical activity of the heart and rule out if heart abnormalities were the cause of the stroke.

Diagnostic Test Reference:

Yu, A. Y. X., & Coutts, S. B. (2018). Role of Brain and Vessel Imaging for the Evaluation of Transient Ischemic Attack and Minor Stroke. *Stroke*, *49*(7), 1791–1795. https://doi.org/10.1161/strokeaha.118.016618

Current Medications

Home Medications

Brand/Generic	Myberiq	Nexium	Amlodipine	Lisinopril	Pravastatin

	(Mirabegron)	(Esomeprazole)	(Norvasc)	(Qbrelis)	(Pravachol)
Dose	50 mg	40 mg	10 mg	10 mg	40 mg
Frequency	Every 24 hours daily at night	Daily every morning	Daily every morning	Daily every morning	Daily every night
Route	Oral (tablet)	Oral (capsule)	Oral (tablet)	Oral (tablet)	Oral (tablet)
Classification	Beta-3 adrenergic agonist	Proton Pump Inhibitors (PPIs)	Calcium channel blockers	Angiotensin-Converting Enzyme (ACE) inhibitors	HMG-CoA reductase inhibitors (statins)
Mechanism of Action	Blocks the neurotransmitter acetylcholine in the central and the peripheral nervous system and stops involuntary bladder contractions	It works by decreasing the amount of acid your stomach makes. This medication helps heal acid damage to the stomach and esophagus.	Lowers the BP by preventing calcium from entering the cells of your heart and arteries. Calcium causes the heart and arteries to contract more strongly. By blocking calcium, it allows the blood vessels to relax and open.	Works by blocking the body that causes the blood vessels to tighten. It relaxes the blood vessels. It lowers BP and increases the supply of blood and oxygen to the heart.	It works by slowing the production of cholesterol in the body to decrease the amount of cholesterol that may build up on the walls of the arteries and block blood flow to the heart, brain, and other parts of the body.
Reason Client Taking	Patient has a history of overactive bladder.	Patient has a history of chronic reflux esophagitis.	Patient has a history of hypertension.	Patient has a history of high blood pressure.	Patient has a history of hyperlipidemia.
Contraindications (2)	Hypersensitivity and uncontrolled hypertension	diarrhea from an infection with Clostridium difficile bacteria and inadequate vitamin B12	hypersensitivity to dihydropyridines and severe hypotension	Hyperkalemia, history of angioedema and renal failure	Alcoholism, uncontrolled epilepsy and liver failure
Side Effects/Adverse Reactions (2)	Increased BP, headache, dizziness, back pain and constipation	Headache, decreased appetite and constipation	Swelling, pulmonary edema and headache	Dizziness, dry hacky cough, headache and diarrhea	Yellowing eyes/ skins, muscle pain, N/V, common cold
Nursing Considerations (2)	May increase BP and angioedema	Monitor for signs and	Monitor patient carefully (BP,	Monitor BP and arrange	Monitor for joint pain or

		symptoms of adverse CNS effect (vertigo, agitation, depression) and check the patient's medical record for an allergy	cardiac rhythm, and output) while adjusting drug to therapeutic dose; use special caution if patient has CHF. Monitor BP very carefully if patient is also on nitrates.	for reduced dosage in patients with impaired renal function	muscle pain and tenderness or weakness. Monitor for a fever.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess patient for urinary urgency, frequency, and urge incontinence periodically during therapy. Monitor BP prior to starting and periodically during therapy.	Monitor INR/PT with concurrent warfarin use. Lab tests: Periodic liver function tests, CBC, Hct & Hbg, urinalysis for hematuria and proteinuria.	Assess cardiac rhythm and platelets	Monitor potassium, BP, BUN/ creatinine	Labs: liver function test and cholesterol levels Monitor coagulation studies and CPK
Client Teaching needs (2)	Take this medicine with a full glass of water. If you take mirabegron wit h solifenacin, take both medicines at the same time each day. You may take these medicines with or without food. Swallow the tablet whole and do not crush, chew, or break it.	Should be taken at least one hour before a meal. Swallow the pill whole and do not crush, chew, break, or open it.	Follow your diet, medication, and exercise routines very closely. Store at room temperature away from moisture, heat, and light.	Drink plenty of water and it can be taken with or without food	Report unexplained muscle pain, tenderness and weakness. Report signs of bleeding and do not breast feed while taking this drug.

Hospital Medications

Brand/Generic	**Aspirin (Acetylsalicylic**	**Carvedilol (Coreg)**	**Clopidogrel (Plavix)**	**Pantoprazole (Protonix)**	**Heparin (Porcine)**

	Acid)				
Dose	325 mg	25 mg	75 mg	40 mg	5,000 units
Frequency	Daily for 21 days End date: 6/17/21	2x daily with meals	Daily	Daily	Every 8 hours
Route	Oral (1 tablet)	Oral (1 tablet)	Oral (1 tablet)	Oral (1 tablet)	SubQ Injection
Classification	Non-steroidal anti-inflammatory drug (NSAID)	Beta blocker	antiplatelet medications	proton-pump inhibitors	Anticoagulants
Mechanism of Action	Inhibit the activity of the enzyme now called cyclooxygenase (COX) which leads to the formation of prostaglandins (PGs) that cause inflammation, swelling, pain and fever	Binds to beta adrenergic receptors on cardiac myocytes. Inhibition of these receptors prevents a response to the sympathetic nervous system, leading to decreased heart rate and contractility.	It works by preventing platelets (a type of blood cell) from collecting and forming clots that may cause a heart attack or stroke.	It works by decreasing the amount of acid made in the stomach.	Binds and accelerates the activity of antithrombin III, an enzyme which causes blood to clot by acting on a blood protein called fibrogen. It also inhibits coagulation factors Xa and IIa
Reason Client Taking	Patient has a history of recurrent TIAs.	Patient has a history of hypertension.	Patient is taking this for preventive measures to prevent blood clots.	Patient has a history of chronic reflux esophagitis	Prevent formation of blood clot while being hospitalized due to decrease mobility
Contraindications (2)	Known allergy to NSAIDs and in patients with asthma, rhinitis, and nasal polyps	Severe hypotension, second or third degree AV block	Increased risk of bleeding due to clotting disorder, bleeding within the skull	Inadequate vitamin b12 and kidney inflammation	Bleeding, operation on the spine and eye surgery
Side Effects/Adverse Reactions (2)	Rash, abdominal pain, upset stomach and heartburn	Tiredness, weakness, dizziness and N/V	Excessive tiredness, headache, dizziness and nausea and vomiting	N/V, dizziness and diarrhea and headache and gas	Pain, bruising, fever, bleeding
Nursing Considerations (2)	Consider bleeding problems and allergy	Monitor BP and pulse frequently during dose	Clopidogrel may make you bruise and bleed more	Can cause hyperglycemia, abdominal pain	Monitor for signs of bleeding

		adjustment period and periodically during therapy.	easily, have nosebleeds, and it will take longer than usual for bleeding to stop.	and increase bleeding with warfarin	Administer in subcutaneous tissue
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess pain and/or pyrexia one hour before or after medication. Monitor renal and liver function and ototoxicity	Assess for orthostatic hypotension when assisting patient up from supine position. If heart rate decreases below 55 beats/min, decrease dose. Monitor intake and output ratios and daily weight.	Assess for bleeding, bruising Assess platelet labs	Assess for occult blood, liver enzymes and assess symptoms of heart burn	Monitor platelet labs and monitor PT
Client Teaching needs (2)	Do not take more or less of it or take it more often than directed by the package label or prescribed by your doctor. Swallow the extended-release tablets whole with a full glass of water. Do not break, crush, or chew them.	Works best if you take it with food, at the same time every day. Swallow the extended-release capsule whole and do not crush, chew, break, or open it.	Contact doctor about any serious bleeding, such as: unexplained, prolonged, or excessive bleeding	Do not breast feed while taking this drug and contact doctor if signs of blistering or skin rash or hives	Rotate site and monitor for signs of bleeding

Medications Reference:

Institute for Safe Medication Practices: ISMP Medication Safety Alert

http://www.ismp.org/. Jones & Bartlett Learning. (2019). 2019 Nurse's Drug

Handbook. Burlington, MA

Assessment

Physical Exam

GENERAL: **Alertness:**	Patient is an elderly Caucasian female. She appears to be alert and orientated to situation and person, time and place. When asked what year and month it was,

Orientation: **Distress:** **Overall appearance:**	the patient answered correctly. Patient knew exactly where she was and for what. Patient denies use of hearing aids. Patient uses glasses for reading her books and newspapers. Patient uses partial dentures in her lower teeth. Patient denies the use of any other assistive devices like a walker, wheelchair or cane prior to hospitalization. Patient appears to be well groomed and in no acute distress, well-developed and not ill-appeared and awake. Patient opens eye spontaneous. Patient's speech is clear. Patient was calm and cooperative. Patient appears stated age. Patient's mood and behavior is normal. **Patient denies fatigue, weight changes, fevers, chills, night sweats at the time of this assessment.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is warm, pink and dry. No rashes or lesions or erythema. Patient has no drainage. Patient has bruises on right abdomen and right lower arm, when asked patient stated it was from her IV and her heparin injection. Patient is not pale or ashy. Patient's nails are without clubbing and cyanosis. Skin turgor normal mobility, quick to return to original state. Patient had no wounds at the time of this assessment. Patient's Braden score is a 20 sensory perception 4 (no impairment), moisture 4 (rarely moist), activity 3 (walks occasional), mobility 3 (slightly limited), nutrition 3 (adequate), friction shear 3 (no apparent problem). **Patient denies rashes, lesions, non-healing sores, hair changes, purities.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head and neck are symmetrical. Trachea is midline without deviations, thyroid is not palpable, no nodules noted at the time of assessment. Bilateral carotid pulses are palpable and strong. No swollen lymph nodes in the head or neck region. Bilateral sclera white, bilateral cornea clear. Bilateral conjunctiva pink, no visible discharge in eye bilaterally. Bilateral lids are pink and dry without lesion. PERRLA bilaterally, red light reflux present bilaterally. Septum is midline. Bilateral frontal sinuses are nontender and to palpation. Bilateral auricles moist and pink without lesions noted. Dentition is good, oral mucous overall is moist and pink without lesions noted and intact. Patient uses partial dentures in lower teeth. Patient's hair is thick, short, white and even distribution. Oropharynx is clear. No discharge present right and left ear. External right and left ear normal. Normal range of motion and neck supple. Patient denies use of hearing aids. Patient denies frontal sinus pain. **Patient denies experiencing headaches, head injury, blurry vision, double vision, earache, drainage, nasal congestion, nose bleeds, nasal drainage, dry mouth, sore throat, swallowing difficulty at the time of the assessment.** **Glasgow coma scale: 15** **(4 spontaneous (best eye response), 6 obeys command (best motor response), 5 oriented (best verbal response))**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.**	Clear S1 and S2 sounds heard without the presence of murmurs, gallops or rubs. PMI at 5th intercostal space at MCL. All extremities warm, pink and dry. Peripheral pulses are 1+ throughout bilaterally. Patient's carotid pulses are 3+

Cardiac rhythm (if applicable): **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒ Edema Y ☐ N ☒** **Location of Edema:**	bilaterally throughout. Patient's radial and ulnar pulses are 3+ bilaterally throughout. Patient's brachial pulse is 3+ bilaterally throughout. Patient's posterior tibial pulse in her right extremity is a 3+ whereas in the patient's left extremity was noticeable weakness and a 2+. Patient's dorsalis pedis pulse is her right extremity is a 3+ whereas in her left extremity it was were faint and almost had to detect at a 1+. This is a result of her recurrent TIA. Capillary refill less than 3 seconds in fingers and toes bilaterally throughout. No neck vein distention noted in this patient. Patient denies shortness of breath with activity or change in position. Patient uses no oxygen and is currently on room air. **Patient denies chest pain, palpitations, diaphoresis, PND, Orthopnea, claudication.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular, even and symmetrical and nonlabored bilaterally. Lung sounds are clear throughout bilaterally. No wheezes, crackles or rhonchi noted. Bilateral equal air entry. **Patient denies wheezing, cough, increase in sputum production. Anterior, lateral, clear and equal bilaterally.**
GASTROINTESTINAL: **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 ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Normal bowel sounds are present. Abdomen is soft, non-distended and non-tender throughout abdomen.** Patient is currently on a regular diet while being hospitalized. Patient describes her diet at home as being "normal" and "regular". Patient states she enjoys drinking coffee throughout the day. Patient states every breakfast for her consist of a banana and coffee and most of the time oatmeal. Patient also states she enjoys eating chicken for dinner. Patient describes her diet as being healthy for the most part. Patient is 5'4" and weights 116 pounds (52.6 kg) with a BMI of 19.91. This patient is considered to be within normal range. Patient shows no indicators for nutrition risk. Patient requires no feeding assistance and tolerances meals well. Patient's abdomen is soft, flat, no masses noted upon light and deep palpation of all the four quadrants. Patient denies tenderness in any of her four quadrants with deep and light palpation. Bowel sounds are hypoactive in all four quadrants. Patient swallows' food without difficulty and has no indicators of nutrition risks. Patient's last bowel movement was three days prior to admission so 5/25/21. Patient describes her bowel movement as being normal. Patient stated her stool was a medium amount. Patient is passing flatus and tolerating a regular diet well. Patient states that going three days without a bowel movement is within normal range for her. Although this is normal, the patient's bowel sounds were hypoactive in all four quadrants so this can be concerning. The patient also was administered a laxative the night prior with no pending results. Patient denies feelings of constipation. **Patient denies nausea, vomiting, diarrhea, abdominal pain, heartburn, jaundice, hematochezia, melena at the time of the assessment.** **Patient's last bowel movement was 5/25/21.**
GENITOURINARY:	Patient's urine appears to be yellow, clear and absent of foul odor. Patient has a

Color: **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	normal stream of urine and consent flow. Patient's genitals appear to be intact, no abnormalities noted. Patient denies episodes of incontinence. Patient voids spontaneous without difficulty. Patient voided once during my shift and was not incontinent. Patient's urine was clear yellow, no malodor and not cloudy. Patient stated she has no difficulty urinating or starting urinary flow at the time of this assessment. Patient denies use of depend at night due to incontinence at the time of this assessment. **Patient denies burning or pain, hematuria, flank pain while urinating.**
MUSCULOSKELETAL: **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** ☐ **X**	Patient appeared to be alert LOC. Patient arousal level was she opened her eyes spontaneously. Patient is a one assist with a walker. Patient demonstrated active range of motion bilaterally throughout. When doing active range of motion extension, it was clear to see that the patient had a bit of difficulties fully extender her left extremity. Patient fall risk score is a 23 (2 – mobility deficit/ weakness, 2 – cardiovascular medication, 2 – age greater than 65, 8 – patient unable to rise from sitting and 8 – unsteady gait/ weakness). Patient is fully independent prior to being hospitalized. Patient is a one assist with a gait belt and walker to the bedside commode and when ambulating in the halls. Patient demonstrated active range of motion bilaterally throughout. Patient is a one assist with ambulation, transferring, toileting, bathing, dressing. Patient is independent with eating, communication and swallowing. Patient maintains good balance independently. Patient tolerated ambulation well. Patient showed no signs of difficulty breathing. Patient needed assist with cueing and set up. Patient's general motor response was normal. Hand grip in left extremity was weaker bilaterally in comparison to her right hand grip bilaterally. Patient's dorsiflexion in her left extremity was noticeably weaker in comparison to her right extremity when dorsiflexing bilaterally. The patient's plantar flexion was weak in her left extremity bilaterally; however, it was strong in her right extremity bilaterally.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient's speech was logical, well-paced, spontaneous and clear. Patient's mood and behavior was cooperative, calm and talkative. Patient's memory was normal. PERRLA bilaterally. Patient's hand grip and ankle strength were strong in her right hand and weak in her left hand bilaterally. Patient is alert and orientated to situation and person, time and place. Patient is full concisions and alert. Patient displays no signs of confusion. CAM score negative. No acute, inattention, altered LOC, disorganized thinking.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:**	Patient copes with anxieties, fears and concerns by watching TV. Patient stated her family is a good support and highly participate in her care and are very motivating. Patient's developmental level is appropriate for her age. Patient

Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	stated she is Buddhists. Patient stated she attends a temple periodically prior to COVID. Patient states she now worships from home. Patient stated her religion means a lot of her, as she grew up supported by religion. Patient lives in her husband. Patient states she considers her two children and husband to be a part of her support team. Patient states her husband is very supportive throughout her care as well as her daughter.

Vital Signs

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0752	70 bpm (right radial)	189/61 (right arm; HOB 30)	18 (unlabored)	97.2 F (oral)	100% (room air)
1101	69 bpm (right radial)	137/65 (right arm; HOB 30)	16 (unlabored)	97.6 (oral)	98% (room air)

Vital Sign Trends: Patient has an extensive history of hypertension. Patient was hypertensive in when taking her morning vital signs. However, after administering her morning medications,

Carvedilol, it is clear to see a deduction in her blood pressure. Showing her medication has been effective. All other vital signs are within normal range for this patient.

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
0762	Numeric	N/A Patient denies experiencing any pain.	0/10	N/A	N/A
1101	Numeric	Patient states she has mild pain in her legs from physical therapy and ambulating in the halls.	2/10	Patient describes pain as being present and consistent. Patient denies feelings of sharp or dull.	Darkened room Patient refused mediation and stated the pain was not severe enough to require the assist of medication. Patient stated she just wanted her overhead light turned off and her plates walked.

IV Assessment

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Placement date/ time was 5/28/2121 upon admission. Location: medial cubital vein (antecubital fossa), left Gauge/ length: 20 gauge Indication/ daily review of necessity is for fluid therapy, medication therapy. Site preparation/ maintenance is depressing; dry and clean and intact. Securement is secured with sterile tape strips. Single lumen patency/ maintenance is flushed without difficulty; flushed per policy. No signs or symptoms of phlebitis and infiltration. The patency of this patient's IV was verified and documented during shift.

Intake and Output

Intake (in mL)	Output (in mL)
Patient is not on a strict intake and output. Patient drank	Patient voided twice throughout my shift on the bedside

240 mL of water throughout the shift. Patient drank 2 cups of black coffee (with no sugar or creamer; 240 mL) throughout my shift. Patient ate 2 slices of wheat bread with strawberry and butter. Patient ate one medium sized banana and one cup of orange juice (180 mL) as well as one cup of oatmeal. **Total Intake: 660 mL**	commode with a one assist and a walker and gait belt. Patient's void was an unmeasurable amount. Patient urine was clear, yellow and feel of foul odor. Patient stated she has no difficulties urinating or starting urine stream.

Nursing Care

Summary of Care

Overview of Care:

Patient is a one assist with a walker and gait belt. Patient ambulated approximately 70 feet with physical therapy during the shift. Patient use an assistive device during ambulation and tolerated it well. Patient returned to bed the remaining of the shift. Patient ambulated twice to the bedside

common, one after breakfast and once again prior to the arrival of her lunch. Patient's urine was yellow and clear with no foul odor present Patient denies being short of breath. Patient required one assist with morning care and dressing. Patient was independent for her oral hygiene. Patient vitals were obtained approximately 0752 and again at 1101. Patient's morning medications were administered to her at 0930. Patient denies pain throughout shift, rating her morning pain at a 0/10 and then her afternoon pain a 2/10 due to therapy. Patient denied pain medication. Patient was rounded on hourly and encouraged to increase her fluids.

Procedures/testing done:

Most of patient's lab values were within normal limits upon admission with the except of a few such as her BUN, lymphocytes and glucose. A follow up lab was not done at the time of this assessment. This patient did not have any procedures or testing done during my shift. This patient did have an NIH stroke scale assessment conducting by the nurse. I stood by while the nurse explained what she was doing as well as her findings. The nurse stated this patient's results were all within normal range and showed no progressive abnormalities or deficits in her any of her extremities that differed from her previous NIH scale assessment. No changes were noted for his patient.

Complaints/Issues:

Patient denies any complaints or issues throughout my shift. At the time of the pain assessment at 1101, this patient did state her pain was a 2/10 being that she ambulated with therapy and request her overhead light be turned off.

Vital Signs (stable/unstable):

Patient's vital sign were elevated, nurse was notified. With the exception of her morning blood pressure, all other vital signs for this patient were within normal range and stable. Patient's morning blood pressure that was taken at 0752 was 189/61 which is elevated. Patient was administered carvedilol during her morning medication. It was effectiveness in lower in blood pressure. When taken again at 1101, her blood pressure was now at 137/65. Patient's vital signs will continue to be monitored throughout the shift.

Tolerating diet, activity, etc.:

Patient ate her breakfast at approximately 0830 and then shortly after toileted herself with one assist, gait belt and a walker. Patient required no assistance with feeding. Patient tolerated regular diet well and ate 75% of her meal which consist of 2 slices of toast, oatmeal and a medium sized banana. Patient drank 450 mL for breakfast which consist of coffee and water.

Physician Notifications/ Future Plans for Patient:

The plan for this patient is to be discharge to an acute inpatient rehab for 3-4 weeks to address impairments and functional limitations. During inpatient rehab, treatment will include ADLs, balance training, endurance training, mobility/ transfer, neuro re-education and safety. Her doctor is wanting her to continue the use of aspirin, Plavix and pravastatin and continue to receive physical therapy upon discharge. The doctor anticipated date of discharge to be tomorrow (6/2/21).

Discharge Planning

Discharge Location:

Upon discharge, patient will be admitted to an acute inpatient rehab facility.

Home health needs (if applicable):

Patient will not require home health care upon discharge, as she will being admitted to an acute inpatient rehab facility. Upon discharge from the rehab facility, she may require more home health needs in the beginning until she makes a full recovery. However, at the time of this assessment no home health needs are required or recommended.

Equipment needs (if applicable):

Patient will not require equipment needs upon discharge. However, when discharge from rehab, it is recommended the patient uses a wheeled walker.

Follow up plan:

Post discharge for this patient will include her continuing with PT and OT therapy inpatient and follow up with neurology in 2-3 weeks as well as on 9/20/21 at 1300 and resume hypertension medication. Patient is also scheduled to have a CMP follow up lab to be completed by 6/30/21. Fasting is not required for this lab. Patient states her overall goal is “I want my left side stronger”. In doing so with the help of PT and OT, this patient will be able to maintain gravity for ten seconds in her left side. Patient demonstrates progress towards goals as evidence by increase ambulation distances with decrease level of assistance.

Education Needs:

Patient will require education on medication, follow up medications, when to seek medical attention for new symptoms, deep breathing exercise to manage pain, how to take new medications or home medications and sides effects, fall prevention, prevention from infection, stroke education and risk factors associated with that, signs and symptoms such as altered LOC, confusion, facial or arm numbness/weakness and VTE prevention.

Nursing Diagnosis

Nursing Diagnosis	Rational	Intervention	Evaluation
1. Ineffective cerebral tissue perfusion **related to** interruption of blood flow, lack of adequate oxygen supply to brain **as evidence by** changes in motor or sensory response in the patient's left	This nursing diagnosis is very prevalent to this patient due to her reasoning in being admitted for a recurrent TIA. Patient presented to the ED on 5/28/21 with	**1.** Monitor for changes in blood pressure throughout shift on 6/1/21 from 0700 to 1400 and compare to baseline. **2.** Position the	**1.** Goal met. Patient's blood pressure was closely monitored through shift on 6/1/21 from 0700 to 1400 to assess for abnormalities that differ from her baseline. At 0752 when obtaining her vitals, her BP was 189/91 which is elevated. After administered her hypertensive medication Carvedilol, her blood pressure returned to a normal

extremities, sensory deficits, patient stated upon admission that her left arm felt “weak and numb” which resulted in the patient’s husband having to lower her to the ground, changes in vital signs, patient presented to the emergency room with an elevation in blood pressure despite her hypertensive baseline it was even more elevated upon admission	numbness and weakness in her left extremities which is highly indicative of a TIA. A TIA effects cereal and tissue perfusion by reducing it due to the sudden interruption of the blood supply to the brain. This can be detrimental to the patient because poor perfusion to the brain can lead to blockage of blood flow which can ultimately result in death. It is important to monitor BP as this can be a precipitating factor to a TIA (Vera, 2013).	patient’s head of the bed to be slightly elevated and in a neutral position throughout shift on 6/1/21 from 0700 to 1400 to reduce arterial pressure and improve cerebral perfusion.	range of 137/65 at 1101. The nurse was notified about the change in her blood pressure. Patient’s blood pressure was continued to be monitored throughout shift. 2. Goal met. Patient was able to maintain a semi fowler position throughout my shift on 6/1/21 from 0700 to 1400. It was explained to the patient the importance in doing so especially with her recurrent TIA episodes. Patient voiced understanding and stated she preferred for the head of the bed to be slightly elevated anyways and not completely flat being that that is what is most comfortable for her.
2. Impaired physical mobility **related to** neuromuscular weakness and flaccid **as evidence by** left sided numbness and weakness according to the patient, limited range of motion, slowed movement of left extremity, muscle grip strength weak in left extremities, gait changes and decreased strength and requires help from another person for assistance and equipment device like a wheeled walker	Being that this patient has had recurrent TIAs, some of the symptoms as a result of it such as weakness, numbness or paralysis of her left side and loss of balance and coordination, this can result in her experiencing difficulties with physical mobility. Prior to admission, P.C. stated she functioned independently at home and without an assistive device, now she is reliant on at least one person for transfer and toileting as well as ambulation.	**1.** Assist patient with exercise and perform ROM exercises for both the affected and unaffected sides by 1400 on 6/1/21 to help with muscle stiffness. **2.**Assist patient to sitting position by raising head of bed, assist to sit on edge of bed and then assist to standing balanced position by 1400 on 6/1/21.	**1.** Goal met. Patient was able to perform active range of motion of both extremities bilaterally throughout by 1400 on 6/1/21. Patient was able to extend and hyperextend her arms and legs bilaterally throughout. Patient displayed signs of deficit in her left arm and left leg. Patient was not able to fully hyperextend her left arm. Patient tolerated the ROM well and stated she was familiar with the exercises because she does them during PT. 2. Goal partially met on 6/1/21. I was able to observe her work with PT. PT made her get in a sitting position which the patient was able to do with minimal assistance. When it came to the patient then rising to a balanced standing position, the patient had moderate swaying. Patient was unable to regain her balance independently and the PT assisted with holding her up for a little. Then the patient was able to maintain her balance and ambulate within the

	This shows the decline in her physical mobility.		room with a gait belt and front wheeled walker well.
3. Risk for fall **related to** hypoxia, possible syncope, altered sensory reception **as evidenced by** numbness and weakness in the patient's left extremity, unsteady gait, fall risk score of 23, antihypertensive medication (Carvedilol)	This patient is at an increased risk for fall due to her one sided weakness and numbness in her left extremity. This patient also a high fall risk with a score of 23 (2 – mobility deficit/ weakness, 2 – cardiovascular medication, 2 – age greater than 65, 8 – patient unable to rise from sitting and 8 – unsteady gait/ weakness). Patient also has a bed and chair alarm. Patient also wears yellow nonskid socks when out of bed. This patient also has clear signs of mobility problems, balance disorders and impaired vision (glasses). This patient also is on antihypertensive medications which increases her risk for falling due to a common side effect dizziness or lightheadedness and drowsy.	**1.** With each encounter with the patient, explain the importance of using the call light and remind patient to call and wait on nurse before getting out of bed throughout shift from 0700 to 1400 on 6/1/21. **2** Guarantee appropriate room lighting, especially during the night and environment is free of cluster from 0700 to 1400 on 6/1/21.	1. Goal Met. Patient was free from injuries and falls during shift on 6/1/21 from 0700 to 1400. With each encounter with the patient, I explained the important of using the call light. I rounded on the patient frequently. When coming in contact with patient, I was sure to ask her if she needed to be toileted or if I could assist her with anything while I was in there to decrease her chances of falling. Patient verbalize that she understood the important or calling for help and demonstrated the use of using her call light if needing help. 2. Goal Met. I was sure to declutter the patient's room and keep patient's phone, tv remote and call light within reach and the windows open to provide adequate lighting throughout my shift from 0700 to 1400 on 6/1/21.
4. Self-care deficit **related to** neuromuscular impairment, decreased strength and endurance and loss of muscle	Due to her recurrent TIAs, this patient is no longer fully independent with care. Prior to admission, this	**1.** Avoid doing things for patient that patient can do for self but provide assistance as necessary	**1.** Goal met. Patient was able to assist in a much of her ADLs as possibly during my shift on 6/1/21. Patient was able to brush her teeth on her own as well as provide personal hygiene care during toileting. I informed the patient that it is

coordination **as evidenced by** impaired ability to perform ADL, inability to put on or take off clothing without assistance and difficulty completing toileting task without assistance	patient was fully independent with her ADLs with the exception of driving. Now, she requires assistive personnel and assistive device to aide in her ADLs. Patient is unable to perform self-care activities within level of own ability at the moment.	throughout shift on 6/1/21 to maintain her self-esteem and help with recovery and independence. **2.** Place food and utensils on the tray related to patient's unaffected side for breakfast and lunch on 6/1/21.	important for her to do as much for herself as she can for as long as she can to help with her independence and recovery. With this, I was sure to tell her I would be here throughout the process in case she did require help. 2. Goal met. I was sure to place her meals one the side stronger side which is her right side during my shift on 6/1/21. This way the patient is able to exercise her independence with feeding herself.

Other References (APA):

Ackley, B. J., Ladwig, G. B., & Makic, M. B. (2017). Nursing diagnosis handbook: An evidence-based guide to planning care (11th ed.). St. Louis, MO: Elsevier

Vera, M. (2013, July 31). *8+ Cerebrovascular Accident (Stroke) Nursing Care Plans*. Nurseslabs. https://nurseslabs.com/8-cerebrovascular-accident-stroke-nursing-care-plans/

Concept Map (20 Points):

Subjective Data

- Presented to the ED with complaints of left arm weakness and numbness
- According to patient's husband, P.C. was too weak and unable to stand so he had lower her to the ground
- Problem was resolved prior to admission
- Patient stated symptoms began after noon
- Patient stated the problem resolved on its own, prior to admission

Objective Data

- CT angio head scan showed no acute hemorrhages or infarctions
- Patient did have mild to moderate atherosclerosis in some of the vessel.
- BP elevated at 0752 (189/91)
- 23 fall risk score
- One assist with a walker and gait belt
- When doing active range of motion extension, it was clear to see that the patient had a bit of difficulties fully extender her left extremity. Patient fall risk score is a 23 (2 – mobility deficit/ weakness, 2 – cardiovascular medication, 2 – age greater than 65, 8 – patient unable to rise from sitting and 8 – unsteady gait/ weakness).
- Hand grip in left extremity was weaker bilaterally in comparison to her right hand grip bilaterally. Patient's dorsiflexion in her left extremity was noticeably weaker in comparison to her right extremity when dorsiflexing bilaterally. The patient's plantar flexion was weak in her left extremity bilaterally; however, it was strong in her right extremity bilaterally.

Patient Information

P.C. is an 88 year old female who was recently seen and admitted and discharged for a TIA. Patient presented to the hospital with complaints of left arm weakness which was resolved. Patient presented with left arm weakness which resulted in patient's husband lowering her to the floor at home because she became weak and "could not stand well" according to her husband. Patient stated her left arm felt weak and numb. Patient stated the onset of her TIA symptoms started early afternoon around noon. Patient stated the symptoms were in her left arms. Patient described the pain as being weak and numb. Patient stated it just went away on its own. Patient represented to the hospital several times with TIA symptoms which were all resolved by the time she came to the hospital. R.C. stated before she came to the hospital but resolved when she was seen in the emergency room. A CT angio head scan was done which was indictive of no acute hemorrhages or infarctions. Patient did have mild to moderate atherosclerosis in some of the vessel. P.C. has a past medical history of supraventricular tachycardia, TIA, chronic foot ulcer, hyperlipemia, hypertension, chronic reflux esophagitis, urinary infection (9/28/20), urge incontinence, stroke lacunar (2/20/20).

Nursing Diagnosis/Outcomes

1. Ineffective cerebral tissue perfusion **related to** interruption of blood flow, lack of adequate oxygen supply to brain **as evidence by** changes in motor or sensory response in the patient's left extremities, sensory deficits, patient stated upon admission that her left arm felt "weak and numb" which resulted in the patient's husband having to lower her to the ground, changes in vital signs, patient presented to the emergency room with an elevation in blood pressure despite her hypertensive baseline it was even more elevated upon admission

   1a. Goal met. Patient's blood pressure was closely monitored through shift on 6/1/21 from 0700 to 1400 to assess for abnormalities that differ from her baseline. At 0752 when obtaining her vitals, her BP was 189/91 which is elevated. After administered her hypertensive medication Carvedilol, her blood pressure returned to a normal range of 137/65 at 1101. The nurse was notified about the change in her blood pressure. Patient's blood pressure was continued to be monitored throughout shift.

   1b. Goal met. Patient was able to maintain a semi fowler position throughout my shift on 6/1/21 from 0700 to 1400. It was explained to the patient the importance in doing so especially with her recurrent TIA episodes. Patient voiced understanding and stated she preferred for the head of the bed to be slightly elevated anyways and not completely flat being that that is what is most comfortable for her.

2. Impaired physical mobility **related to** neuromuscular weakness and flaccid **as evidence by** left sided numbness and weakness according to the patient, limited range of motion, slowed movement of left extremity, muscle grip strength weak in left extremities, gait changes and decreased strength and requires help from another person for assistance and equipment device like a wheeled walker

   2a. Goal met. Patient was able to perform active range of motion of both extremities bilaterally throughout by 1400 on 6/1/21. Patient was able to extend and hyperextend her arms and legs bilaterally throughout. Patient displayed signs of deficit in her left arm and left leg. Patient was not able to fully hyperextend her left arm. Patient tolerated the ROM well and stated she was familiar with the exercises because she does them during PT.

   2b. Goal partially met on 6/1/21. I was able to observe her work with PT. PT made her get in a sitting position which the patient was able to do with minimal assistance. When it came to the patient then rising to a balanced standing position, the patient had moderate swaying. Patient was unable to regain her balance independently and the PT assisted with holding her up for a little. Then the patient was able to maintain her balance and ambulate within the room with a gait belt and front wheeled walker well.

Nursing Interventions

1a. Monitor for changes in blood pressure throughout shift on 6/1/21 from 0700 to 1400 and compare to baseline.

1b. Position the patient's head of the bed to be slightly elevated and in a neutral position throughout shift on 6/1/21 from 0700 to 1400 to reduce arterial pressure and improve cerebral perfusion.

2a. Assist patient with exercise and perform ROM exercises for both the affected and unaffected sides by 1400 on 6/1/21 to help with muscle stiffness.

2b. Assist patient to sitting position by raising head of bed, assist to sit on edge of bed and then assist to standing balanced position by 1400 on 6/1/21.