Demographic Data

Date of Admission: 07/05/2021

Admission Diagnosis: Transient ischemic attack (TIA)

Chief Complaint: “I feel weak”

Age: 80

Gender: Female

Race/Ethnicity: Caucasian

Allergies: No Known Allergies

Code Status: D.N.R.

Height in cm: 165.5cm

Weight in kg: 53.5 kg

Psychosocial Developmental Stage: Integrity vs. despair

Cognitive Developmental Stage: Formal operational

Braden Score: 14

Morse Fall Score: 60

Infection Control Precautions: Standard precautions.

Medical History

Previous Medical History: Hypertension, Hyperlipidemia, & Gout.

Prior Hospitalizations: No recent hospitalizations within the last 3 years, reported by the client.

Chronic Medical Issues: Hypertension, Hyperlipidemia, & Gout.

Social History: Client denies smoking or chewing tobacco use. Client denies the use of smokeless tobacco. Client reports consuming 3.6 oz of beer per a week. Client denies the use of illegal drugs.

Admission History

The client felt the need to seek medical care when she became weak in the middle of the night and struggled to get out of bed. She explained that she felt like something was wrong.

She was brought to the hospital after she called her son to bring her in. She was having weakness and was unable to get out of bed by herself. This is not normal for her as she lives at home alone and is independent.

Her symptoms of weakness were managed by her son helping her to get dressed and out of bed. He assisted her into the car and drove her to the hospital.

Pathophysiology

A transient ischemic attack (TIA) is known as a temporary period of symptoms similar to a stroke. A transient ischemic attack has the exact origins of an ischemic stroke, a common type of a stroke. In an ischemic stroke, a clot blocks the blood supply to a part of your brain. Unlike a stroke, the blockage is only brief in a transient ischemic attack, and there is almost no permanent damage. An underlying cause of a TIA is often a

buildup of cholesterol-containing fatty deposits called plaques (atherosclerosis) in the artery or one of its branches supplying oxygen and nutrients to the client's brain. The plaques can reduce the blood flow through an artery or lead to a clot or clots development.

Transient ischemic attacks usually last only a few minutes. Most of the signs and symptoms disappear within an hour, though symptoms can last up to 24 hours. The signs and symptoms of a TIA resemble those found early in a stroke and may include abrupt onset of weakness, numbness or paralysis in the client's face, arm, or leg, typically on one side of your body, mumbled or garbled speech, or difficulty understanding others, blindness in either one or both eyes or double vision, and vertigo or loss of balance or coordination.

Several tests may be implemented to confirm a TIA and look for problems that could have caused it. The client's blood pressure will be checked because high blood pressure can lead to TIAs. An electrocardiogram (ECG) can measure your heart's electrical activity using several electrodes attached to the client's skin. An ECG can detect abnormal heart rhythms, which may signify conditions such as where your heart beats irregularly, which then can increase your risk of developing a TIA. A carotid ultrasound scan can show any narrowing or blockages in the neck arteries leading to the client's brain. A small probe sends high-frequency sound waves into the client's body. When these sound waves then bounce back, they can create an image of the inside of the client's body. MRI scan is the most often used to diagnosis the problem. This kind of scan uses a strong magnetic field and then uses radio waves to create an image of the client's brain.

Treatment can vary based on how severe the TIA was on the client. Some options include changing to a heart-healthy diet and engaging in the recommended weekly exercise. That is, for most people, this means at least 150 minutes of moderate-intensity activity. If the client is a smoker, they will be encouraged to quit. Cutting down on alcohol consumption is an important teaching point as well. Most people who have had a TIA will need to take one or more medicines every day, long term, to help reduce their chances of having a stroke or another TIA, Such as Aspirin and other antiplatelet medications. Anticoagulant drugs are essential and can help to prevent blood clots by changing the chemical composition of the client's blood in a way that stops clots from then forming. If the client is hype3rtensive, they might be placed on an antihypertensive drug to bring it down. The same thing with cholesterol, If they are high, they might be put on a statin medication. For a surgical option, a carotid endarterectomy involves removing part of the lining of the carotid arteries that is the main blood vessels that supply the head and neck, and then any of the blockages inside the carotid arteries.

Lab Values/Diagnostics

Glucose - 146 Normal 60-99
Can be elevated in response to stress (Pagana et al., 2018). This could be elevated as the client is very stressed with her current health situation.

Lymphocytes - 13.8% Normal 20-40%
Can be decreased in response to severe stress (Pagana et al., 2018). The client is very worried with her current health state.

MRI – Will be completed soon. Client was unable to complete the scan prior due to anxiety. Important to complete as it can confirm the TIA diagnosis.

CT - CT angiogram of the head and neck showed no significant stenosis. Used for diagnosis and rule out.

Active Orders

The client is planned to complete an MRI with sedation. Important to complete as it can confirm diagnosis.

The client is on a Two hour turn schedule. Important to complete as it can prevent pressure injuries and skin break down.

Client is NPO until a speech language consult. This is important to ensure the client is safe to swallow and prevent the client from choking.

Client is on bed rest and fall risk. This is important as the client needs to rest and because the client is having weakness on one side of her body.

Vitals and pain assessment Q2 hours. This is important to assess the client because of her diagnosis and compare results to baseline data. The clients blood pressure has been high and needs close monitoring.

Physical Exam/Assessment

General: Client is A/O x2. This is compared to the baseline data of the client being A/O x4. This finding is consistent with the diagnosis of TIA. The client is weaker on her right side. Appearance is appropriate.

Integument: On the client weaker side, Skin is intact, dry, and warm to the touch. No bruising, rashes, tears, or wounds noted.

HEENT:

Cardiovascular: S1, S2, noted. Pulses 3+ bilaterally. No edema noted. Cap refill < 3.

Respiratory: No accessory muscle use. Equal non labored respirations. The client has right sided weakness but is breathing normally and has a 98% pulse ox reading on room air.

Genitourinary:

Musculoskeletal: Client's strength is not equal. Right sided weakness noted. Strength on right side rated at a 3. Left side strength rated at a 5. This is a finding that can be the result of the TIA or stroke.

Neurological: Client oriented to person and birthdate. Client is unable to tell the place or the time. A/O x 2. This finding is consistent with the TIA diagnosis.

Most recent VS (include date/time and highlight if abnormal): 2335 7-06-2021.
Temp – 97.8F Oral **HR –** 92 **BP –** 132/94 **02 –** 98% on room air. **RR -** 14
Pain and pain scale used: 0 and Adult Numerical Rating Scale (NRS)

Medication

Allopurinol – xanthine oxidase inhibitors – Client is taking this medication for their chronic Gout. The nurse should review the Complete blood count, liver function tests, renal function, and serum uric acid levels before administration (Jones & Bartlett Learning, 2020).

Atenolol – Beta Blocker – Client is on this medication for her Hypertension. The nurse should assess the patient's apical pulse and blood pressure to confirm they are within normal range (Jones & Bartlett Learning, 2020).

Tylenol – analgesics (pain relievers) and antipyretics (fever reducers). – Client is taking this medication for pain. The nurse should assess the clients pain level prior to administration. The nurse should review the client's hepatic labs as the medication is hard on the liver (Jones & Bartlett Learning, 2020).

Nursing Diagnosis 1	**Nursing Diagnosis 2**	**Nursing Diagnosis 3**
Ineffective Tissue Perfusion related to interrupted blood flow as evidenced by memory loss.	Impaired Physical Mobility related to Hemiparesis as evidenced by the nurse and student nurse's assessment of the client and finding the client suffers from weakness on her right side.	Ineffective Coping related to current health crisis as evidenced by the client stating, "I don't need this and I need to go home."

Rationale This was chosen as the client is now AO x2. The client was previously AO x4. The client knows her name and birthdate. The client now does not know where she is or what is today's date. This information is now being compared to her baseline data. The clients change in AO was noticed this morning at the beginning of the shift.	**Rationale** The nurse and the student nurse assessed the client. We found that the client has increased weakness on the right side of her body. This is a new finding when compared to the baseline data.	**Rationale** The client lives at home alone and does not want to be in the hospital. She has trouble understanding why she is here and frequently asking her son to take her home right away.
Interventions **Intervention 1:** Maintain bedrest, provide quiet and relaxing environment, restrict visitors and activities (Hinkle & Cheever., 2018). **Intervention 2:** Closely assess and monitor neurological status frequently and compare with baseline.	**Interventions** **Intervention 1:** Observe affected side for color, edema, or other signs of compromised circulation. **Intervention 2:** Change positions at least every 2 hr.	**Interventions** **Intervention 1:** Identify previous methods of dealing with life problems. **Intervention 2:** Encourage patient to express feelings, including hostility or anger, depression, sense of disconnectedness.
Evaluation of Interventions The interventions will be continued. The neurological assessments are helping to provide an accurate tool to look back on. The nurse will continue with closely assessing the client and reporting to the physician when it is appropriate. The bedrest and relaxing environment are	**Evaluation of Interventions** The nurse and student have continued to monitor for color, edema, and other signs of poor circulation. The client is now being repositioned in bed every 2 hours. So far, the client's skin has been normal and	**Evaluation of Interventions** The nurse and the student nurse provided a calm, safe and supportive environment. This allowed the client to feel comfortable to share her feelings on the situation. She is very frustrated but is trying to be positive with the situation at hand. She confirmed that she will try to pull for past health

seeming to calm the client.	no complications have been found.	experiences and figure out what helped her get through it.

References (3) (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

Jones & Bartlett Learning. (2020). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.