N321 Care Plan #2

Lakeview College of Nursing

Kaitlyn N. Holycross

Demographics (3 points)

Date of Admission 9/14/21	**Patient Initials** RLT	**Age** 85	**Gender** Male
Race/Ethnicity White	**Occupation** Retired	**Marital Status** Married to Shirley	**Allergies** No known allergies
Code Status Full Code	**Height** 5’ 11”	**Weight** 215 lbs. BMI: 29.99	

Medical History (5 Points)

Past Medical History:

Arthritis, Bilateral hearing loss, Cancer (prostate, colon), Heart failure with preserved election fraction, Carcinoma of ascending colon, DVT, Bilateral lower limbs, and Memory loss.

Past Surgical History:

Hemicolectomy

Family History:

NA

Social History (tobacco/alcohol/drugs):

Former smoker (cigarettes, cigars, and chew) for 15 years (1 pack per day). No alcohol or drug use.

Assistive Devices:

NA

Living Situation:

Currently living at home. Not a good candidate for inpatient rehab currently.

Education Level:

NA

Admission Assessment

Chief Complaint (2 points):

Bilateral weakness and facial droop. Came in to rule out a stroke.

History of present Illness (10 points):

Bilateral weakness and facial droop has a strong correlation to a patient having a stroke of some kind. Patient's wife stated that her husband was feeling numbness and mild confusion earlier on in the day. The symptoms progressed in the evening when she found her husband in the bathroom on the floor. He stated that he had fallen and then didn't know where he was. The wife noticed he had bilateral weakness and a facial droop so they took him to the ER where he was examined. The patient is currently being constantly monitored by an EEG for brain activity because of suspected seizures.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):

Stroke

Secondary Diagnosis (if applicable):

Aspiration pneumonia

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

A stroke is a brain injury which can be a result of either a hemorrhage of a cerebral blood vessel or ischemia of the brain tissue (Capriotti, 2020). A stroke is described as a clinical syndrome that is a result of disruption in cerebral triggers which essentially abrupt neurological deficits that are permanent. A hemorrhagic stroke is caused by the cerebral artery rupturing and hemorrhaging. Once this occurs, it leads to compression and toxicity of brain cells which then causes a loss of

cerebral blood flow. The other kind of stroke is labeled as an ischemic stroke which is due to a thrombus or embolus lodging in a cerebral artery which then cuts of the blood flow to the brain. Ischemic strokes are much more common than hemorrhagic strokes. Approximately 85% of stokes are due to ischemia (Capriotti, 2020). It is also possible for injury to the brain to be caused by a TIA, otherwise known as a transient ischemic attack. A TIA occurs when there is a disruption of cerebral circulation which can involve neurological deficits. These deficits, unlike ischemic and hemorrhagic strokes, are reversible and last for less than 24 hours. The body is able to dissolve the clot on its own during this circumstance. TIA's are often an indication of potential future stokes and should still be taken seriously. Implications of strokes defer based on the severity of the stroke, and which side of the brain it effects. Left brain strokes can cause speech and language issues, memory loss, behavioral style is slower, and paralysis on the right side of the body. Right brain strokes cause vision problems, behavioral style is quick, memory loss, and paralysis on the left side of the brain (American Stroke Association, 2021).

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives (2nd edition).* Philadelphia: F.A. Davis.

American Stroke Association (2021). *Effects of Stroke*. https://www.stroke.org/en/about-stroke/effects-of-stroke

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	4.40-5.80x10^6/mcL	4.12	3.97	Could be a vitamin B6, B12, or folate deficit. Poor nutrition (malnourished). Possibly internal bleed
Hgb	13.0-16.5g/dL	13.8	13.2	
Hct	38.0-50%	39.3	39.5	
Platelets	140-440x10^3	204	151	
WBC	4.00-12.00x10^3/mcL	13.07	8.06	
Neutrophils	40.0- 68.0%	NA	5.53	Chemo, autoimmune disease, bone marrow disorder. Pt could also be deficient in vitamin B12, folate or copper.
Lymphocytes	19.0-49.0%	NA	11.3	Infection or illness
Monocytes	100-700	NA	12.5	Bloodstream infection, chemo/radiation
Eosinophils	0.0- 6.0	NA	5.7	
Bands	0-500	NA	NA	

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-	134-145mEq/L	131	137	
K+	3.6-5.2	3.7	4.0	
Cl-	98-107mEq/L	100	101	
CO2	23- 29	22.0	28.0	
Glucose	70-100	116	106	Only slightly elevated. Pt is not diabetic and is receiving tube feeding. Unsure why it would be slightly higher.
BUN	7-20	12	19	
Creatinine	0.6-1.3	0.84	0.84	

Albumin	3.4-5.4	3.7	2.7	Inflammation shock. Malnutrition. Crohns or celiac disease
Calcium	8.7-10mg/ dL	NA	9.3	
Mag	1.7-2.2	1.6	1.9	
Phosphate	3.4-4.5	NA	NA	
Bilirubin	0.1-1.2	Neg	0.7	
Alk Phos	20-130	67	53	
AST	8-33 U/L	26	36	Not super alarming given that it is only slightly higher. However, could indicate pancreas, liver, or heart problems (pt has heart failure)
ALT	7-55 U/L	14	20	
Amylase	40-140 U/L	NA	NA	
Lipase	24-151 U/L	NA	NA	
Lactic Acid	4.5-19.8 mg/ dL	NA	NA	

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	1.1 or below for people not taking blood thinners	1.1	1.1	
PT	11-13.5 seconds	13.0	13.9	Slightly elevated. Too long to form a clot. Vitamin K deficiency, liver disease, or a coagulation disorder.
PTT	25-35	37	200	Longer blood clotting time. Can be caused by certain medications, liver disease or kidney disease

D-Dimer	less than 0.50	NA	NA	
BNP	less than 125 pg/mL	NA	NA	
HDL	60 mg/dL or higher	45	NA	Greater risk of developing heart disease
LDL	less than 100mg/dL	117	NA	At risk for heart attack or stroke. Can limit blood flow. Not good cholesterol (pt is experiencing stroke symptoms, this may be a contributor. Also pt has heart failure)
Cholesterol	125-200mg/ dL	180	NA	
Triglycerides	less than 150 mg/dL	88	NA	
Hgb A1c	Below 5.7%	NA	NA	
TSH	0.5-5.0mlU/ L	1.484	NA	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow/clear	Straw/clear	Straw/ clear	
pH	5.0-9.0	7.0	7.0	
Specific Gravity	1.003-1.030	1.003	1.006	
Glucose	Negative	Neg	Neg	
Protein	Negative	100	100	Kidney disease can be a cause
Ketones	Negative	Trace	Neg	Diabetic ketoacidosis
WBC	Neg, 0-5/hpf	5	3	
RBC	Neg, 0-2/hpf	0	8	Infection in urinary tract, bladder, or kidneys (pt has a Foley so there could be some infection going on)
Leukoesterase	0-5 WBC	Neg	Neg	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture			NA	
Blood Culture			NA	
Sputum Culture			NA	
Stool Culture			NA	

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). Davis Advantage for Pathophysiology: *Introductory Concepts and Clinical Perspectives (2nd edition)*. Philadelphia: F.A. Davis.

MedlinePlus. (2020). *MedlinePlus*: *U.S National Library of Medicine*. https://medlineplus.gov/

Medscape. (2020). *Medscape*. https://reference.medcape.com/

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

*RN bedside swallow screening results: Positive screening (high risk for dysphagia)- 9/14

*Nuclear Medicine Lung Perfusion Scintigraphy: SPECT CT images show bilateral altered perfusion noted with multiple large segmental areas of hypoperfusion notes bilaterally. Limited

non-contrast. CT images show minimal dependent atelectasis with no facial infiltrate identified. No pleural fluid- 9/21

*Chest X-ray- Mild pneumonia

*CTA head and neck- Negative for infarction

*CT Brain- Negative for infarction

Diagnostic Test Correlation (5 points):

Patient's CT and CTA came back normal showing no infarction present. This was a big concern given that his chief complaint was bilateral weakness and facial droop. However he luckily has a negative CVA or cerebrovascular accident. The chest X-ray did identify aspiration pneumonia. Patient was given a swallow test and the test demonstrated dysphagia or difficulty swallowing. There was a note in the chart that stated he experienced encephalopathy which is damage to the brain. It was stated this was because of seizures or potential stroke.

Diagnostic Test Reference (1) (APA):

MedlinePlus. (2020). *MedlinePlus*: *U.S National Library of Medicine*. https://medlineplus.gov/

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

Home Medications (5 required)

Brand/Generic	Vacuum evection device system Warfarin (Coumadin)	Telmisartan (Micardis)	Tadalafil (Cialis)	Niacin ER (Niaspan ER)	Calcium carbonate-Vitamin D (Caltrate-600+Vit D)
Dose	6 mg	40 mg	20 mg	500 mg	600 mg
Frequency	Daily	Daily	PRN (As needed)	QID (4 times daily)	BID (two times daily)
Route	Oral	Oral	Oral	Oral	Oral
Classification	Anticoagulant	Angiotensin receptor blocker	Phosphodiesterase-5 Enzyme inhibitor	Antilipemic agent/ high cholesterol	vitamin
Mechanism of Action	Inhibiting the synthesis of vitamin K dependent clotting factors	Blocks the vasoconstrictor aldosterone-secreting effects of angiotensin II by selectively blocking the binding of angiotensin	Cyclic GMP causes smooth muscle relaxation	Inhibits a hormone-sensitive lipase in adipose tissue	Calcium helps build and maintain bones while vitamin d helps your body effectively absorb calcium

		II to the AT1 receptor			
Reason Client Taking	stroke	High blood pressure	Erectile dysfunction	High cholesterol	Bone protection
Contraindications (2)	Recent brain, eye or spinal cord injry or surgery. Severe liver or kidney disease	Dehydration, High levels of potassium in the blood	Multiple myeloma, alcohol intoxication	Active liver disease, active peptic ulcer disease	Decreased kidney function, Kidney stones
Side Effects/Adverse Reactions (2)	Easy bruising and bleeding, vomiting	Dizziness, Flu-like symptoms	Flushing, headaches	Flushing reaction, Headaches	Nausea/ vomiting, loss of appetite
Nursing Considerations (2)	Watch out for bleeds, injury control, look out for bloody stool.	Monitor Blood pressure	Contact provider if loss of vision or hearing occur	Assess for muscle weakness and tenderness or weakness	Monitor parathyroid hormone

Hospital Medications (5 required)

Brand/Generic	Albuterol HFA 90 mcg Actuation inhaler	Atorvastatin (Lipitor)	amlodipine (Norvasc)	Alum-mag hydroxide-Simeth oral suspension	Aspirin tablet

Dose	2 puff	40 mg	10 mg	30 mL	325 mg
Frequency	4 hours PRN	Daily with every meal	Daily	Every 6 hours PRN	Daily
Route	inhalation	Gastric tube	Oral	Gastric	Oral
Classification	Bronchodilator	Lipid lowering agent	Calcium channel blocker	Antacid	Anti-innflammatory
Mechanism of Action	acts on beta-2 adrenergic receptors to relax the bronchial smooth muscle	selective, competitive inhibitor of HMG-CoA reductase	Inhibits the transmembrane influx of calcium ions into vascular smooth muscle and cardiac muscle	Restoring acid-base balance, attenuating the pepsin activity and increasing bicarbonate and prostaglandin secretion	inhibit the activity of of enzyme cyclooxygenase (COX) acetylating the hydroxyl of serine residue
Reason Client Taking	COPD	High cholesterol	High blood pressure	GERD	Heart protection
Contraindications (2)	overactive thyroid gland Excess body acid	Alcoholism Liver failure	Cardiogenic shock, severe aortic stenosis	Decreased kidney function, Blockage of the intestines with stool	Asthma, nasal polyps
Side Effects/Adverse Reactions (2)	Nervousness Headache	Muscle pain diarrhea	Headache, flushing	Chalky taste, constipation	Heartburn Nausea
Nursing Considerations (2)	Monitor respiratory rate, oxygen levels, and lung sounds before and after administering it	liver function tests and lipid panel should be done first for a baseline to go off of	Make sure to monitor blood pressure	Note stools because it can cause decreased bowel movements	Tell pt to keep an eye on bleeding. Drink lots of water and no alcohol

Medications Reference (1) (APA):

2020 Nurse's Drug Handbook (9th edition). (2020). Burlington, MA, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** Alert **Orientation:** x3 **Distress:** None **Overall appearance:** Overall clean, no smell. Hair was a mess from the cords on his head.	When pt was awake he was alert. He was slightly confused as to where he was and what day it was.
INTEGUMENTARY (2 points): **Skin color:** Pt had proper skin color for race **Character:** Dry **Temperature:** Warm to touch **Turgor:** Normal skin turgor **Rashes:** No rashes **Bruises:** No bruising that I saw **Wounds:** No visible wounds **Braden Score:** 16 **Drains present: Y☐ N ☒** **Type:**	Pt's skin was a little dry on his legs. Chest port had recently been changed so skin was completely normal with no drainage.
HEENT (1 point): **Head/Neck:** Symmetrical, no lumps on his head, and no palpable lymph nodes **Ears:** No drainage, had trouble hearing **Eyes:** White, clear, no obvious drainage, no irritation, passed PERRLA and ROM, symmetrical. Has glasses **Nose:** No deviated septum, symmetrical upon inspection **Teeth:** Oral care was subpar	Pt could not hear very well at all. When you would talk to him you would have to yell and that didn't even work most of the time. Communication was very difficult with the patient given his hearing loss and that he slept a lot. Patient has a hearing-aid but it does not have proper batteries and he doesn't like to wear them.
CARDIOVASCULAR (2 points): **Heart sounds:** Heart sounds were normal, no murmurs **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** NA **Peripheral Pulses:** Not easy to find, but	Pt is dealing with some peripheral edema which made it harder to deal with pulses. Pt has a IPC or compression sleeve for legs since he is immobile and has had a past DVT

present **Capillary refill:** Less than 3 seconds **Neck Vein Distention: Y** ☐ **N** ☒ **Edema Y** ☒ **N** ☐ **Location of Edema:** Peripheral	
RESPIRATORY (2 points): **Accessory muscle use: Y**☐ **N** ☒ **Breath Sounds: Location, character:** Wheezing. Posterior breath sounds were diminished	Pt is dealing with some mild pneumonia which is most likely correlated to the wheezing. Pt is utilizing a nasal cannula for oxygen.
GASTROINTESTINAL (2 points): **Diet at home:** NA **Current Diet:** Tube feeding **Height:** 5' 11" **Weight:** 215 lbs. **Auscultation Bowel sounds:** Active **Last BM:** When I was there at 0950 **Palpation: Pain, Mass etc.:** **Inspection:** Good upon inspection. Round **Distention:** Normal **Incisions:** None present **Scars:** None that I could see **Drains:** None **Wounds:** None **Ostomy: Y** ☐ **N** ☒ **Nasogastric: Y** ☒ **N** ☐ **Size:** I did not find out **Feeding tubes/PEG tube Y** ☒ **N** ☐ **Type:** Nasogastric	Was not able to get an answer from pt about current diet at home. BMI indicates overweight Was receiving a feeding when I was there. We set it up Pt is not supposed to get out of the bed, but refused to have a BM in bed. Three people helped him up and placed him on a commode Pt has a nasogastric tube for medications and tube feeding
GENITOURINARY (2 Points): **Color:** Straw/clear **Character:** pH was 7.0 **Quantity of urine:** 1000 mL **Pain with urination: Y** ☐ **N** ☒ **Dialysis: Y** ☐ **N** ☒ **Inspection of genitals:** **Catheter: Y** ☒ **N** ☐ **Type:** Foley **Size:** I did not find out	
MUSCULOSKELETAL (2 points): **Neurovascular status:** No pain present **ROM:** Limited range of motion **Supportive devices:** Full support	Patient is to remain in the bed or chair at all times. Cannot move by himself. He was very shaky when we transferred him from the bed to the chair. Pt was out of breath for awhile after the

Strength: Low strength **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 45 **Activity/Mobility Status:** Not mobile **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	transfer. Does not have full range of motion with hands due to gloves/mitts he has to wear.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no - Legs ☒ Arms ☐ Both ☐** **Orientation:** x3, communicates every so often but not well **Mental Status:** Confused. Cannot fully communicate **Speech:** Speaks clear **Sensory:** Decently aware, cannot hear well so hard to tell **LOC:** Not in hospital	Communication issues could be due to sleeping, confusion, and most importantly hearing loss Patient is confused of his limitations as well. He tries to get out of bed and go to the bathroom. He also gets frustrated with his situation at times. Pt had mitts put on his hands because he tried taking out his nasogastric tube multiple times. Therefore, he gets agitated easily with that.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** NA **Developmental level:** Decreasing **Religion & what it means to pt.:** NA **Personal/Family Data (Think about home environment, family structure, and available family support):** Support from wife Shirley	Patient is confused so developmental level is not highly appropriate. Was not able to have him explain religion or coping mechanisms due to sleeping and hearing loss.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	64	146/76	18	97.8	97% nasal cannula
1045	64	148/77	18	97.8	97% nasal cannula

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	0/10	No pain	No pain	NA	NA
1045	0/10	No pain	No pain	NA	NA

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g **Location of IV:** left forearm **Date on IV:** 9/14 **Patency of IV**: Efficacy working, proper blood return and administration of IV **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Clean, no drainage, swelling or bruising	At the time pt was just receiving fluids along with feeding tube. Pt also has a left chest port.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
250 mL + 80 mL in tube for meds (330 mL total)	1000 mL

Nursing Care

Summary of Care (2 points)

Overview of care:

Patient is being examined and monitored for the stroke symptoms he experienced before coming to the ER. His chief complaint was bilateral weakness with a facial droop. However, he had a negative CVA. While in the hospital they did a chest X-ray and found he has mild pneumonia. He was placed on a feeding tube. One of the reasons is because he did not pass a

swallow test which diagnosed him with dysphagia. He had a Foley catheter inserted because he is on bedrest. He struggles to walk and needs full assistance. Patient is not fully aware of where he is or what day it is. Therefore, patient is dealing with impaired mental status. He experienced encephalopathy which is damage to the brain. His brain therefore is being constantly monitored. Lastly, patient is also dealing with some peripheral edema which could be a correlation to his heart failure.

Procedures/testing done:

A swallow test was performed which indicated dysphagia. A Foley catheter and nasogastric tube was inserted. He had a chest X-ray which indicated pneumonia. Lastly, he is currently being monitored in his room with an EEG to watch for certain brain activities. The patient experienced stroke symptoms, and encephalopathy which indicated seizures. A CT was done which showed negative for infarctions. Nuclear Medicine Lung Perfusion Scintigraphy was also performed which indicated no pleural fluid.

Complaints/Issues:

Patient does not complain of any pain. However, patient tried taking out his nasogastric tube so they had to put mitts on him. Also, he forgets where he is and why he needs to stay in bed and tries to get out. He gets a little aggravated when he wants the gloves off and to move around. He has many issues such as heart failure, currently dealing with pneumonia, seizure activity, and symptoms of stroke even though his CVA was negative.

Vital signs (stable/unstable):

Vital signs are stable

Tolerating diet, activity, etc.:

No activity for the patient. Diet is from tube feedings

Physician notifications:

NA

Future plans for patient:

Goals for this patient include possibly being transferred to an inpatient rehab facility. However, they will not accept him with his mitts or nasogastric tube. Another goal is to ensure his peripheral edema is managed and pneumonia is gone. Lastly, ensuring he is not at risk for clots which could prevent a future stroke is essential. He also has heart failure so making sure he has proper blood flow. Lastly, the EEG would spot any unusual brain activity that could lead to future brain health.

Discharge Planning (2 points)

Discharge location:

Back home unless they can get him accepted into an inpatient rehab facility.

Home health needs (if applicable):

He would need in home care for tube feedings and moving around since he cannot walk on his own. This is only if he is still on tube feedings and cannot get accepted into a facility.

Equipment needs (if applicable):

NA

Follow up plan:

Follow up with bloodwork and ensure medications are working to prevent strokes and seizures.

Education needs:

Educate patient on the severity of moving around without assistance. Also, ensuring the patient is aware that wearing his hearing-aid is critical for communication. Lastly, taking the proper medications regularly.

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. Risk for falls	I could've chose many nursing diagnoses for this patient. I picked risk for falls for this first one because when I was there he tried getting up multiple times with his bed alarm going off. He wanted to go use the restroom and we couldn't let him. He had wires everywhere from the EEG, hand mitts, a Foley catheter, and compression sleeves on his legs. He also cannot walk on	**1.** Keep the bed alarm on at all times. Being aware that he could get up is critical for fast response. **2.** Explaining to the patient the risk of him getting up is essential. Even though he forgets. He understands once you remind him.	The family (his wife) want what's best for him and his safety. Right now while he is under the care of the hospital and currently having everything hooked up to him, it is safer for him to remain in bed. The client will most likely not be happy and state that he wants to use the restroom. However, explaining to him in a calm manner that he can hear will help him understand and calm him down.

	his own at all so this was a huge no for him to get up. However, since he gets confused and agitated, he likes to do what he wants. This could cause major harm for him to get up on his own so he is at risk for falls.		
2. Decreased cardiac output	I chose decreased cardiac output because the patient is dealing with heat failure. Part of heart failure involves the heart not meeting the needs and demands of the body. His heart condition could also correlate with his peripheral edema.	**1.** Ensuring the patient stay on top of his home medications such as coumadin will ensure he can have adequate blood flow. **2.** Patient should get regular labs drawn to ensure heart failure is not becoming worse. Another point to add would be if he gets off of tube feeding, he should follow a cardiac diet which include less fried fatty foods and more healthy fats such as avocados and olive oil.	The family is fully supportive in trying to ensure he stays consistent with medications and doctor visits. The patient understands the severity of taking the medication once you can explain to him why it is needed. Patient is compliant.
3. Risk for aspiration	Patient was diagnosed with aspiration pneumonia. This puts him at risk of aspirating more and causing him to choke. The RN also performed a swallow test which he failed (indicating dysphagia).	**1.** Elevate the head of his bed to ensure anything he spits or coughs up does not go down into his lungs. This is critical during tube feedings as well. **2.** Monitor level	The patients family is aware of the severity of him aspirating. Interventions will continue even after discharge to prevent the worsening or further worsening of the aspiration pneumonia which could cause choking. The patient is not too happy about having the head of the

	Therefore, proper airway maintenance is critical to ensure he does not aspirate and cause harm.	of consciousness because this could be a big cause of aspiration.	bed raised, however, he cooperates.

Other References (APA):

Swearingen, P.L., & Wright, J.D. (2019). *All-in-one nursing care planning resource*: Medical-Surgical, Pediatric, Maternity, and Psychiatric- Philadelphia, Missouri: Elsevier Health Sciences.

Concept Map (20 Points):

Subjective Data

*Patient comes into ER with complaints of a facial droop and bilateral weakness.
*Patient has no pain
*Patient is aggravated with not being able to walk to the bathroom

Nursing Diagnosis/Outcomes

Patients primary diagnosis was stroke. His secondary diagnosis was aspiration pneumonia. It is critical the patient remain on his coumadin to prevent strokes and allow for proper blood flow. Patient also has been previously diagnosed with heart failure which could benefit from proper blood flow. The heart failure could be a cause of the edema he is experiencing. Lastly, the aspiration pneumonia will be treated and precautions will be set in place to ensure he does not aspirate. Elevating the head of the bed and maintaining consciousness will ensure hopefully no aspirating. It is also essential the patient does not get out of bed without full assistance. The goal is to ensure no strokes are present, prevent seizures, and maintain proper blood flow.

Objective Data

*Pt was diagnosed with aspiration pneumonia and peripheral edema
*Pt had a negative CVA
*Patient has been previously diagnosed with heart failure, colon/prostate cancer, DVT, and bilateral hearing loss
*Patient is currently being monitored with an EEG for brain activity

Patient Information

atient is an 85 year old male. He is 5' 11" and 215 pounds. He has been diagnosed with peripheral edema and aspiration pneumonia. He came in with his wife saying he had a facial droop and bilateral weakness. He was observed for a stroke but they found he was CVA negative. He was previously diagnosed with heart failure, cancer, a DVT, and bilateral hearing loss

Nursing Interventions

Raise the head of the bed to prevent aspirations
Watch out for level of consciousness
Ensure regular medication intake
Receive regular doctor visits and bloodwork
Keep bed alarm on at all times and be aware he could try to get up
Explain the importance of all of these interventions even if it has been explained before. Ensure patient can fully hear and understand what is being said