N321 Care Plan #1

Lakeview College of Nursing

Abbie Morman

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
1/18/2022	R.W.	62	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Carpenter	Divorced	No known allergies
Code Status	**Height**	**Weight**	
Full	5’8”	190 pounds	

Medical History (5 Points)

Past Medical History: Type 2 Diabetes, nicotine abuse, amphetamine abuse, degenerative disc disease.

Past Surgical History: Hernia repair

Family History: Mother had complications with diabetes. Father had heart disease. Patient had 12 brothers and sisters with histories of diabetes and strokes.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient is an avid tobacco and marijuana user. States he smokes a half pack of tobacco a day and uses a vape with marijuana every day. Doesn’t state any alcohol use.

Assistive Devices: No assistive devices used at home prior to admission.

Living Situation: Lives in Indianola with his daughter and 3 grandchildren in a two-story home.

Education Level: Unknown

Admission Assessment

Chief Complaint (2 points): Tingling in left hand

History of Present Illness – OLD CARTS (10 points): Patient reported tingling in his left hand that started 3 days ago. It’s a consistent, uncomfortable feeling. Along with the tingling, patient had generalized weakness, unsteady gait, and lethargy. Raising of this limb makes the tingling

become more apparent and it falls within 3 seconds of lifting. He didn't state any relieving factors. Patient didn't seek medical attention for this, as he hasn't been to the doctors in 5 years.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cerebrovascular accident

Secondary Diagnosis (if applicable): Not applicable

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

Pathophysiology References (2) (APA):

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	4.40-5.80	5.46	5.06	
Hgb	13-16.5	16.5	15.6	
Hct	38-50	48.1	44.2	
Platelets	140-440	296	269	
WBC	4-12	13.30	10.90	
Neutrophils	40-68	77.5	69.5	**Neutrophils could be high because of an acute bacterial infection. (MedicineNet, 2021)**
Lymphocytes	19-49	14.4	21.3	
Monocytes	3-13	7.1	7.7	
Eosinophils	0-8	0.4	1.2	**A high eosinophil count could indicate an allergic reaction, parasitic infection, or in worst scenarios, cancer. (Merck Manual, 2021)**
Bands	NA	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-	133-144	133	135	
K+	3.5-5.1	4.1	3.4	
Cl-	98-107	93	98	
CO2	21-31	29	28	
Glucose	70-99	359	141	**Patient has a history of diabetes. He doesn't manage it at home and he hasn't sought healthcare in 5 years. Which is why his sugar levels were extremely high.**
BUN	7-25	11	11	
Creatinine	0.50-1.20	0.89	0.64	
Albumin	3.5-5.7	4.1	3.8	
Calcium	8.8-10.2	9.3	9.3	
Mag	1.6-2.6	NA	1.9	
Phosphate	34-104	104	93	
Bilirubin	NA	NA	NA	
Alk Phos	**NA**	**NA**	**NA**	
AST	**NA**	**NA**	**NA**	
ALT	**NA**	**NA**	**NA**	
Amylase	**NA**	**NA**	**NA**	
Lipase	**NA**	**NA**	**NA**	

Lactic Acid	**NA**	**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	**0.8-1.1**	**1.1**	**NA**	
PT	**10.1-13.1**	**12.9**	**NA**	
PTT	**NA**	**NA**	**NA**	
D-Dimer	**NA**	**NA**	**NA**	
BNP	**NA**	**NA**	**NA**	
HDL	**<40**	**34**	**NA**	
LDL	**<200**	**202**	**NA**	**High LDL can be because of poor diet. (Zimlich, 2021)**
Cholesterol	**<200**	**202**	**NA**	**High cholesterol can be a result of diet and lifestyle. (Zimlich, 2021)**
Triglycerides	**<150**	**233**	**NA**	**A high count of triglycerides can be caused by diabetes. (Woolley, E. 2020)**
Hgb A1c	**4-6**	**12.8**	**12.3**	**Patient has a history of uncontrolled type 2 diabetes.**
TSH	**NA**	**NA**	**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	Clear and yellow	Clear and yellow	**NA**	
pH	5-9	6.0	**NA**	
Specific Gravity	1.003-1.030	1.033	**NA**	
Glucose	Negative	3+	**NA**	**Glucose found in the urine could**

				indicate diabetic ketoacidosis. (Medline Plus, 2020)
Protein	Negative	Negative	**NA**	
Ketones	Negative	+1	NA	**Ketones found in the urine could indicate diabetic ketoacidosis. (Medline Plus, 2020)**
WBC	Negative	Negative	NA	
RBC	Negative	Negative	NA	
Leukoesterase	NA	NA	NA	

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**	**NA**	**NA**	
Blood Culture	**NA**	**NA**	**NA**	
Sputum Culture	**NA**	**NA**	**NA**	
Stool Culture	**NA**	**NA**	**NA**	

Lab Correlations Reference (1) (APA):

Medline Plus. (2020) Ketones in Urine. Retrieved from Ketones in Urine: MedlinePlus Medical Test.

MedicineNet. (2021) What Does it Mean When Your Neutrophils are High? Retrieved from What Does It Mean When Your Neutrophils Are High? (medicinenet.com).

Territo, M. (2021) Eosinophilic Disorders. Retrieved from Eosinophilic Disorders - Blood Disorders - Merck Manuals Consumer Version.

Woolley, E. (2020) 10 Causes of High Triglycerides in Diabetes. Retrieved from 10 Causes of High Triglycerides in Diabetes (verywellhealth.com).

Zimlich, R. (2021) Why is my Cholesterol High? Retrieved from Why Is My Cholesterol High? Causes, Symptoms, Treatment (verywellhealth.com).

Diagnostic Imaging

All Other Diagnostic Tests (5 points): This patient had a CT of the head/brain and cervical spine, an x-ray of the chest, an EKG, and MRI of the brain upon admission on 1/18/22.

Diagnostic Test Correlation (5 points):

In this patient's scenario, a CT of the head and brain was an essential part of his care because it can be used to determine if the stroke was hemorrhagic or iscshemic. A hemorrhagic stroke occurs when a blood vessel in the brain ruptures, whereas an ischemic stroke occurs when a blood vessel in the brain is blocked. A CT works by scanning the selected body region and taking pictures of the inside of that region. To improve detection, the patient may be given a contrast formula before the scanning. This contrast better highlights the bleeding, if it's present.

An MRI was done on this patient because he suffered from a stroke. Physicians often use this as a way to assess brain damage that is present after a stroke. An MRI uses a powerful, magnetic field, radio frequency pulses and a computer to produce detailed images of organs, tissues, and bones.

An EKG test was also essential for this patient because it can help determine whether heart problems were the cause of the stroke. An EKG's overall goal is to monitor the heart's electrical rhythms. So, if the EKG shows any abnormalities, there's a better chance for the physicians to understand why the stroke occurred and the plan of care will be better formulated.

If the physician is concerned that a stroke occurred because of cardiovascular issues, an x-ray of the chest is ordered. Most often, a chest x-ray is only performed if there's high suspicion that the heart caused the stroke. This is not a part of the mandated routine of stroke patients.

Diagnostic Test Reference (1) (APA):

Radiological Society of North America. (2021) *Stroke*. RadiologyInfo.org. Retrieved from Stroke - Diagnosis, Evaluation and Treatment (radiologyinfo.org).

Mayo Clinic Staff. (2020) *Chest X-rays*. Mayo Clinic. Retrieved from Chest X-rays - Mayo Clinic.

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

Brand/Generic	**Lovenox enoxaparin**	**Lipitor atorvastatin**	**Plavix clopidogrel**	**Hydralazine apresoline**	**Lantus Insulin glargine**
Dose	**40 mg**	**80 mg**	**75 mg**	**10 mg**	**10 units**
Frequency	**Once daily**	**Once at night**	**Once daily**	**Q1 hour PRN**	**Every morning**
Route	**injection**	**oral**	**oral**	**Injection**	**SubQ**
Classification	**Pharm: low molecular weight heparin. Therapeutic: anticoagulants**	**Pharm: HMG-CoA reductase inhibitor. Therapeutic: Antihyperlipi-demic**	**Pharm: platelet inhibitor Therapeutic: platelet aggregation inhibitor**	**Pharm: vasodilator Therapeutic: antihypertensive**	**Pharm; human insulin Therapeutic: antidiabetic**
Mechanism of Action	**potentiates the action of antithrombin III, a coagulation inhibitor.**	**Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver.**	**Binds to ADP receptors on the surface of activated platelets. It prevents fibrinogen from attaching. Which means that platelets can't form.**	**It exerts a direct vasodilating effect on vascular smooth muscle.**	**Lowers blood glucose levels by stimulating peripheral glucose uptake by fat and skeletal muscle.**
Reason Client Taking	**Prevention of blood clots**	**Lower blood cholesterol**	**To reduce thrombotic events, like strokes.**	**High BP**	**Lowering blood sugar**
Contraindications (2)	**Active major bleeding. History of immune-mediated HIT.**	**active hepatic disease. hypersensitivity to atorvastatin.**	**Active bleeding, including intracranial hemorrhage. Hypersensitivity to clopidogrel or its components.**	**CAD Mitral valvular rheumatic heart disease.**	Chronic lung disease Hypersensitivity to regular human insulin or any of its components
Side Effects/Adverse Reactions (2)	**confusion fever and headache congestive heart failure**	**amnesia dizziness cognitive impairment**	**Confusion, depression, dizziness, and fatigue.**	**Chills, fever, headache, angina, and edema.**	**Confusion, dizziness, drowsiness, and fatigue.**
Nursing	**Use extreme**	**Shouldn't be**	**Determine if**	**Give tablets**	Ensure patient

Considerations (2)	**caution in patients who have an increased risk for bleeding. Use extreme caution with patients who have a history of HIT.**	**taken with patients who are using cyclosporine. Expect atorvastatin to be used in patients without obvious CAD but with multiple risk factors.**	**patient has a history of hypersensitivity to this drug. Obtain blood cell count whenever S/S suggest a hematologic problem.**	**with food to increase bioavailability. Monitor blood pressure and pulse rate regularly and weigh patient daily during therapy.**	has had a complete medical history and physical exam before administering. Monitor patient for signs and symptoms of hypoglycemia.

Hospital Medications (5 required)

Brand/ Generic	**Potassium Chloride Klorcon**	**Ondansetron Zofran**	**Nicotine Nicoderm patch**	**Normodyne Labetalol**	**Aspirin Acetylsalicylic acid**
Dose	**20 mEq**	**4 mg**	**1 patch**	**10 mg**	**300 mg**
Frequency	**Once daily**	**Q6 PRN**	**Once daily**	**Q1 hr. PRN**	**Once daily**
Route	**Oral**	**IV**	**Transdermal**	**IV**	**Rectal**
Classification	**Pharm: soluble salts Therapeutic: electrolyte replenisher**	**Pharm: selective serotonin receptor antagonist Therapeutic: antiemetic**	**Pharm: nicotinic agonist Therapeutic: smoking cessation adjunct**	**Pharm: noncardioselective beta blocker. Therapeutic: antihypertensive**	**Pharm: salicylate Therapeutic: NSAIDs**
Mechanism of	**Reverses**	**Blocks**	**Binds**	**Selectively**	**Blocks the**

Action	**symptoms low potassium.**	**serotonin receptors centrally in the chemoreceptor trigger zone.**	**selectively to nicotinic-cholinergic receptors at autonomic ganglia, in the adrenal medulla.**	**blocks alpha and beta receptors in smooth muscle.**	**activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis.**
Reason Client Taking	**To increase potassium**	**To prevent nausea and vomiting.**	**For the relief of nicotine withdrawal symptoms.**	**High BP**	**To relive mild pain or fever**
Contraindications (2)	**Hyperkalemia, hypernatremia.**	**Concomitant use of apomorphine. Hypersensitivity to ondansetron**	**Hypersensitivity to nicotine. Hypersensitivity to menthol or soy.**	**Bronchial asthma, cardiogenic shock.**	**Active bleeding or coagulation disorders.**
Side Effects/Adverse Reactions (2)	**Anxiety, confusion, dizziness.**	**Agitation, akathisia, anxiety. And ataxia.**	**Dizziness, dream disturbances, drowsiness.**	**Anxiety, confusion.**	**Confusion, CNS depression.**
Nursing Considerations (2)	**Monitor serum phosphorus levels and monitor calcium levels.**	**Place tablet on patient's tongue immediately after opening package. Monitor patient closely for signs and symptoms of hypersensitivity to Zofran.**	**Use caution when nicotine is given with active peptic or gastric ulcers. Keep in mind to avoid possible burns, remove patch before MRI.**	**During IV labetalol use, expect to monitor BP according to facility guidelines. Be aware that stopping it abruptly after long term us could result in angina.**	**Don't crush timed release or controlled release tablet unless directed to.**

Medications Reference (1) (APA):

Jones and Bartlett Learning. (2021) *Nurse's Drug Handbook*. Pages 95, 250, 378, 537, 611, 793, 826, 883.

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is alert and oriented times person, place, and time. He doesn't appear to be in any acute distress.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Skin color is pink, cool, and dry to the touch. There are no lesions, rashes, or wounds upon inspection. There is a small bruise on his left hand where the IV is placed. Skin turgor is normal, less than 3 seconds. Patient's braden score is a 13 and is a high fall risk.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck are symmetrical upon inspection and the trachea is midline. There are no noted nodules and the thyroid is nonpalpable. Bilateral carotid pulses are 2+ upon palpation. Bilateral auricles have no visible deformities or lumps present. Bilateral eyes appear to have white sclera with no visible drainage. Bilateral lids appear to have no lesions upon inspection. PERRLA. EOM's are intact bilaterally. Septum is midline with no notable drainage. Oral mucosa is pink and**

	moist with no noted lesions. Patient has clean, intact teeth.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**Normal heart sounds with no murmurs present. Rate and rhythm are normal. Presents with a 2+ pulse upon palpation of all pulse sites. Capillary refill is less than 3 seconds bilaterally. No edema is present.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Clear breath sounds noted in all lung fields. Respirations and patterns are non-labored with a normal respiratory rate. Patient doesn't appear to be using accessory muscles when breathing.**
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:**	**Patient was on a regular diet at home. Upon admission, patient was changed to a diabetic diet. Patient's height is 5'8" and he weighs 190 pounds. Normoactive bowel sounds are present in all quadrants among auscultation. Last bowel movement was 1/20/22. Upon inspection there was no distension, incisions, scars, drains, or wounds present.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:**	**Patient's urine was yellow with no odor. The quantity of urine was unknown. There was no pain with urination and he's not on dialysis. Was unable to examine genitals. Patient had no catheter or trouble with urination.**

Size:	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 9** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk X**	**There was noted weakness on the patient's left side. Patient's left arm and left leg were noticeably weaker than the right. Patient needs help with ADLs. Uses a gait bait and walker when ambulating short distances. 2-3 people are needed to help patient stand and get to the bedside commode. Patient's fall score is a 9.**
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Patient doesn't move all extremities well. Left arm falls within seconds of patient lifting it up. Patient's left arm and left leg were noticeably weaker than the right. Patient is alert and oriented to person, place, and time. Patient is well spoken and answers questions appropriately. PERRLA.**
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient lives in Indianola with his daughter and 3 grandchildren. Patient doesn't have proper coping mechanisms, as evidenced by drug use. Patient's developmental level is appropriate for his age. Patient didn't state any religious practices. Patient has a big family, relies on daughter for care and decision making.**

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0850	**89**	**131/78**	**20**	**97.9 degrees** **F orally**	**97%**
1130	**89**	**121/77**	**20**	**98.0 degrees** **F orally**	**98%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	**0-10**	**Patient states no pain**	**Patient states no pain**	**No pain**	**No pain**
1130	**0-10**	**No pain**	**No pain**	**No pain**	**No pain**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** Left hand **Date on IV**: 1/19/22 **Patency of IV:** dry and intact **Signs of erythema, drainage, etc.:** small bruise on IV site **IV dressing assessment:** sterile tape with securement dressing in place	No fluids were running

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
100% food intake and 240 mL of fluids	**300 mL of urine, unmeasured stool amount**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient tolerated breakfast well. He doesn't report any pain or discomfort. Patient worked with physical therapy. No procedures or testing was done, patient is getting prepared for discharge to home.

Procedures/testing done: Upon admission a CT of the head and neck and a chest x-ray were done.

Complaints/Issues: No complaints were addressed, pain is managed.

Vital signs (stable/unstable): Patient had stable vital signs.

Tolerating diet, activity, etc.: Patient is tolerating diet well. Ambulation is weak, 2-3 people are needed to assist him with standing and pivoting to bedside commode.

Physician notifications: No new orders were given at the time I was present.

Future plans for client: Patient will be discharging with OSF Home Health. Patient will work with physical therapy and have a follow up appointment at OSF Polyclinic.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): OSF Home Health

Equipment needs (if applicable): NA

Follow up plan: Patient has a follow up appointment with his primary care physician at OSF Polyclinic. There will also be home health for nursing PT after discharge.

Education needs: Disease management and education on physical and occupational therapy at home.

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

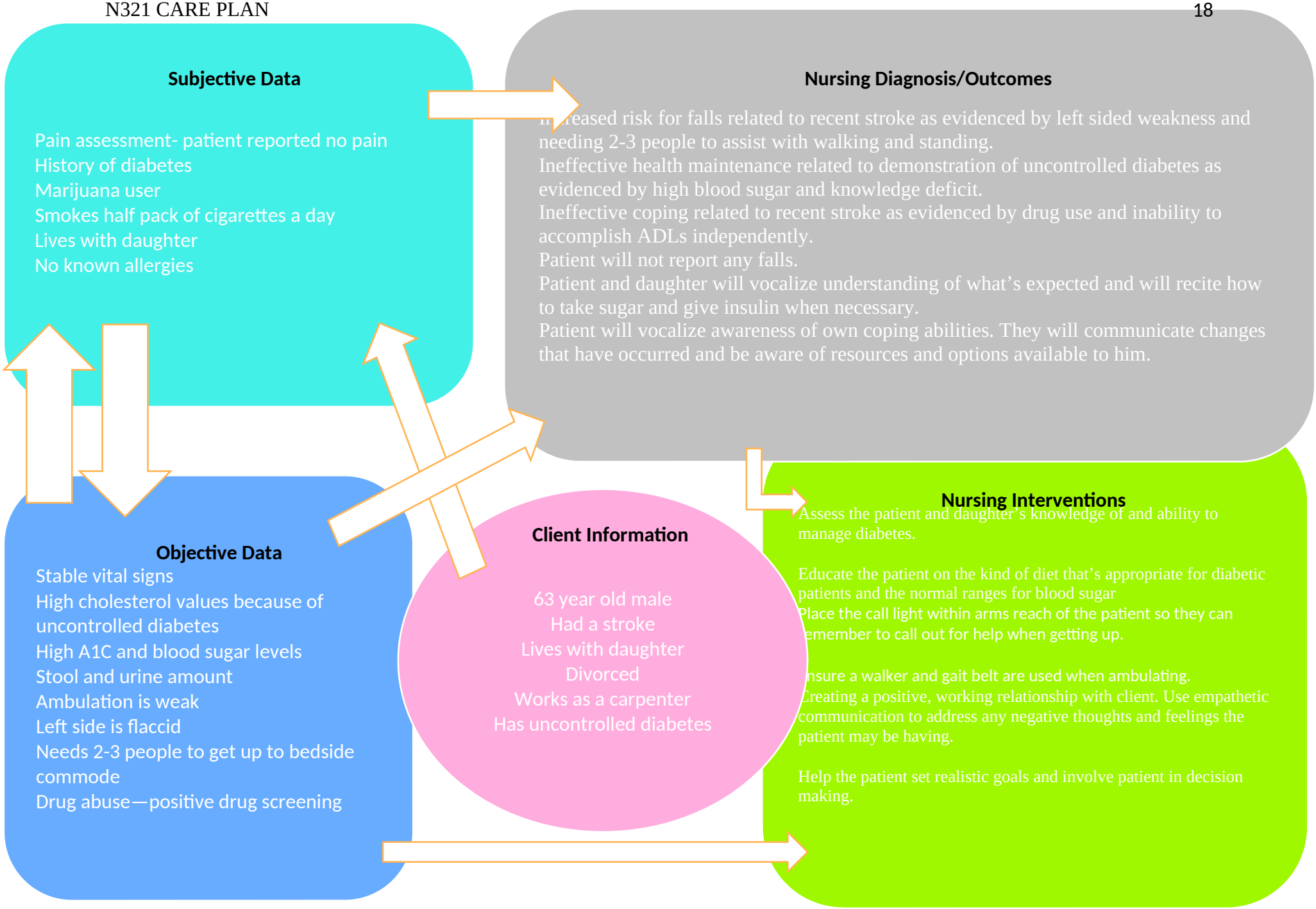
Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client response, status of

priority to lowest priority pertinent to this client				goals and outcomes, modifications to plan.
1. Increased risk for falls related to recent stroke as evidenced by left sided weakness and needing 2-3 people to assist with walking and standing.	This diagnosis was chosen because the patient had a recent stroke. There was noted weakness and he couldn't walk appropriately**.**	**1.** Place the call light within arms reach of the patient so they can remember to call out for help when getting up. **2.** Ensure a walker and gait belt are used when ambulating.	**1.** Patient will not report any falls.	Patient didn't not report any falls and will be safe when ambulating. The patient understands why it's important to call out for help.
2. Ineffective coping related to recent stroke as evidenced by drug use and inability to accomplish ADLs independently.	It was chosen because client had positive drug screening upon admission and is unable to complete tasks independently. This poses a greater risk for the client to have a negative thought process.	**1.** Creating a positive, working relationship with client. Use empathetic communication to address any negative thoughts and feelings the patient may be having. 2.Help the patient set realistic goals and involve patient in decision making.	**1.** Patient will vocalize awareness of own coping abilities. They will communicate changes that have occurred and be aware of resources and options available to him.	Patient communicated needs they had and physical changes that occurred.
3. Ineffective health	It was chosen because the	1. Assess the patient and	1. Patient and daughter will	Patient and daughter

maintenance related to demonstration of uncontrolled diabetes as evidenced by high blood sugar and knowledge deficit.	patient hasn't sought healthcare in 5 years and doesn't know what's expected to manage diabetes.	daughter's knowledge of and ability to manage diabetes. 2. Educate the patient on the kind of diet that's appropriate for diabetic patients and the normal ranges for blood sugar.	vocalize understanding of what's expected and will recite how to take sugar and give insulin when necessary.	understood the normal blood sugar levels and what food is acceptable to eat while being on a diabetic diet.

Other References (APA):

Concept Map (20 Points):


Subjective Data
Pain assessment- patient reported no pain
History of diabetes
Marijuana user
Smokes half pack of cigarettes a day
Lives with daughter
No known allergies
Nursing Diagnosis/Outcomes
Increased risk for falls related to recent stroke as evidenced by left sided weakness and needing 2-3 people to assist with walking and standing.
Ineffective health maintenance related to demonstration of uncontrolled diabetes as evidenced by high blood sugar and knowledge deficit.
Ineffective coping related to recent stroke as evidenced by drug use and inability to accomplish ADLs independently.
Patient will not report any falls.
Patient and daughter will vocalize understanding of what's expected and will recite how to take sugar and give insulin when necessary.
Patient will vocalize awareness of own coping abilities. They will communicate changes that have occurred and be aware of resources and options available to him.
Objective Data
Stable vital signs
High cholesterol values because of uncontrolled diabetes
High A1C and blood sugar levels
Stool and urine amount
Ambulation is weak
Left side is flaccid
Needs 2-3 people to get up to bedside commode
Drug abuse—positive drug screening
Client Information
63 year old male
Had a stroke
Lives with daughter
Divorced
Works as a carpenter
Has uncontrolled diabetes
Nursing Interventions
Assess the patient and daughter's knowledge of and ability to manage diabetes.
Educate the patient on the kind of diet that's appropriate for diabetic patients and the normal ranges for blood sugar
Place the call light within arms reach of the patient so they can remember to call out for help when getting up.
Ensure a walker and gait belt are used when ambulating.
Creating a positive, working relationship with client. Use empathetic communication to address any negative thoughts and feelings the patient may be having.
Help the patient set realistic goals and involve patient in decision making.