N431 Care Plan # 1

Lakeview College of Nursing

Angel Roby

Demographics (3 points)

Date of Admission	**Client Initials**	**Age**	**Gender**
9/21/2022	R.S.	73 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Divorced	NKA
Code Status	**Height**	**Weight**	
Full	178 cm	72 kg	

Medical History (5 Points)

Past Medical History: Atrial fibrillation, hypertension, hyperlipidemia, pre-diabetes, mild mitral regurgitation, abdominal aortic aneurysm, prior CVA with left sided weakness, sleep apnea

Past Surgical History: Wisdom teeth removal (1/12/2018)

Family History: Mother – Diabetes, heart failure (unknown date of death)

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Tobacco (former smoker), alcohol (beer, wine, liquor): 1-2x a week

Assistive Devices: CPAP/BiPAP at home, walker and gait belt in the hospital

Living Situation: Lives at home alone, upon discharge will be going to Hilltop nursing home

Education Level: Bachelor's degree

Admission Assessment

Chief Complaint (2 points): Altered mental status

History of Present Illness – OLD CARTS (10 points): Presented to the ED on 9/21/2022 with altered mental status. Patient was not seen for two days, and the landlord found him with garbled speech. CT of the head shows acute infarct of the left occipital and posterior temporal lobe and showed no hemorrhage. The CTA of the neck shows moderate to severe short segment stenosis

proximal to the right internal carotid 70%. Neurology will come for a consultation before discharge. The patient has no recollection of his time before admission to the ED.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Stroke

Secondary Diagnosis (if applicable): N/A

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

An ischemic stroke formerly referred to as a cerebrovascular accident or “brain attack,” is a sudden loss of function resulting from disruption of the blood supply to a part of the brain (Hinkle et al., 2022). In an ischemic brain attack, there is disruption of cerebral blood flow due to obstruction of a blood vessel. This disruption in blood flow initiates a complex series of cellular metabolic events referred to as the ischemic cascade (Capriotti, 2020). The ischemic cascade begins when cerebral blood flow decreases to less than 25 mL per 100 g of blood per minute. At this point, neurons are no longer able to maintain aerobic respiration. The mitochondria must then switch to anaerobic respiration, which generates large amounts of lactic acid, causing a change in the pH. This switch to less efficient anaerobic respiration also renders the neuron incapable of producing sufficient quantities of adenosine triphosphate (ATP) to fuel the depolarization processes. The membrane pumps that maintain electrolyte balance begin to fail, and the cells cease functioning (Hinkle et al., 2022). The influx of calcium and the release of glutamate, if continued, activate several damaging pathways that destroy the cell membrane, release more calcium and glutamate, vasoconstriction, and the generation of free radicals. These processes enlarge the area of infarction into the penumbra, extending the stroke (Hinkle et al., 2022). The patient may present with any of the following signs or symptoms: Numbness or

weakness of the face, arm, or leg, especially on one side of the body, confusion or change in mental status, trouble speaking or understanding speech, visual disturbances, difficulty walking, dizziness, or loss of balance or coordination, and a sudden severe headache (Hinkle et al., 2022). A non-contrast computed tomography (CT) scan is the initial diagnostic test for a stroke. The CT scan within 20 minutes from the time the patient presents to the emergency department (ED) to determine if the event is ischemic or hemorrhagic, as the type of stroke determines treatment (Hinkle et al., 2022). Studies may include CT angiography or CT perfusion; magnetic resonance imaging (MRI) and magnetic resonance angiography of the brain and neck vessels; transcranial Doppler flow studies; and transthoracic or transesophageal echocardiography. Patients may present to the acute care facility with temporary neurologic symptoms (Hinkle et al., 2022). The patient presented to the ED with altered mental status with garbled speech. The patient had the diagnostic tests listed above to determine whether or not he was having a stroke and if it was ischemic or hemorrhagic. The results showed that there was no hemorrhage. Anticoagulants are prescribed as alternative drugs, including dabigatran, apixaban, edoxaban, or rivaroxaban unless they are contraindicated (Hinkle et al., 2022). The patient is taking rivaroxaban along with aspirin during this clinical course.

Pathophysiology References (2) (APA):

Capriotti, T.M. (2020). *David advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Hinkle, J.L., Cheever, K.H., & Overbaugh, K. (2022). *Brunner & suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80 – 5.41 x 10^6/mcL	4.87 x 10^6/ mcL	4.29 x 10^6/mcL	N/A
Hgb	13 – 17 g/dL	15.4 g/dL	13.6 g/dL	N/A
Hct	38.1 – 48.9 (%)	43.2 %	38.9 %	N/A
Platelets	149 – 393 K/ mcL	162	102	If the patient has had a minor ischemic stroke or what is considered a TIA with a high risk of having a stroke, and they did not receive thrombolytic therapy, they may receive two platelet-inhibiting medications. The aspirin that is taken by the patient is an antiplatelet which explains the low platelet count after the medication was taken (Hinkle et al., 2022).
WBC	4.0 – 11.7 K/ mcL	9.3	5.6	N/A
Neutrophils	2.4 – 8.4 x 10^3/mcL	8 x 10^3/mcL	3.4 x 10^3/mcL	N/A
Lymphocytes	0.8 – 3.7 x 10^3/mcL	0.8 x 10^3/ mcL	1.3 x 10^3/mcL	N/A
Monocytes	0.3 – 1.1 x 10^3/mcL	0.5 x 10^3/ mcL	0.6 x 10^3/mcL	N/A
Eosinophils	0 – 0.5 x 10^3/ mcL	0.4 x 10^3/ mcL	0.2 x 10^3/mcL	N/A
Bands	10 – 16 (%)	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135 – 145 mmol/L	135 mmol/ L	137 mmol/L	N/A

K+	3.4 – 5.1 mmol/L	3.4 mmol/L	3.4 mmol/L	N/A
Cl-	98 – 107 mmol/L	100 mmol/ L	104 mmol/L	N/A
CO2	21 – 31 mmol/L	28 mmol/L	26 mmol/L	N/A
Glucose	74 – 109 mg/dL	301 mg/L	120 mg/ L	The elevated blood glucose level is common in patients diagnosed with diabetes (Hinkle et al., 2022).
BUN	7 – 25 mg/dL	16 mg/dL	10 mg/dL	N/A
Creatinine	0.7 – 1.30 mg/dL	0.79 mg/dL	0.56 mg/dL	Low creatinine levels can indicate a person having low muscle mass or body weight or even malnutrition. Its concentration depends on lean body mass and varies from person to person (Hinkle et al., 2022).
Albumin	3.5 – 5.2 g/dL	4.2 g/dL	N/A	N/A
Calcium	8.6 – 10.3 mg/dL	9.4 mg/dL	8.6 mg/ dL	N/A
Mag	1.6 – 2.2 mg/dL	N/A	N/A	N/A
Phosphate	2.5 – 4.5 mg/dL	N/A	N/A	N/A
Bilirubin	0.3 – 1.0 mg/dL	1.2 mg/dL	N/A	The bilirubin concentration in the blood may be increased in the presence of liver disease, if the flow of bile is impeded (e.g., by gallstones in the bile ducts), or if there is excessive destruction of red blood cells (Hinkle et al., 2022). In this case, the patient does not have a history of liver disease, but it may be a possibility since the patient has risk factors that may contribute to liver disease.
Alk Phos	34 – 104 units/L	64 units/L	N/A	N/A
AST	13 – 39 units/L	23 units/L	N/A	N/A
ALT	7 – 52 units/ L	19 units/L	N/A	N/A

Amylase	100 – 300 units/L	N/A	N/A	N/A
Lipase	0 – 60 units/ L	N/A	N/A	N/A
Lactic Acid	3 – 23 mg/dL	N/A	N/A	N/A
Troponin	0.000 – 0.030 ng/mL	<0.010 ng/ mL	N/A	N/A
CK-MB	96 – 100 (%)	N/A	N/A	N/A
Total CK	36 – 160 units/L	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	< or = 1.1	2.28	N/A	Those with atrial fibrillation (or cardioembolic strokes) are treated with dose-adjusted warfarin with a target international normalized ratio (INR) of 2 to 3 (Hinke et al., 2022). The patient has a history of atrial fibrillation and may have been on warfarin therapy before he was admitted.
PT	11 – 13.5 seconds	26 seconds	N/A	PT measures the extrinsic pathway activity and is used to monitor the level of anticoagulation with warfarin (Hinkle et al., 2022). As stated above, the patient has a history of atrial fibrillation.
PTT	23.0 – 32.4 seconds	32.2 seconds	N/A	N/A
D-Dimer	< 250 ng/mL	N/A	N/A	N/A
BNP	< 100 pg/mL	N/A	N/A	N/A
HDL	23 – 92 mg/dL	45 mg/dL	N/A	N/A
LDL	< 130 mg/dL	121 mg/dL	N/A	N/A

Cholesterol	< 199 mg/dL	187 mg/dL	N/A	N/A
Triglycerides	0 – 149 mg/dL	104 mg/dL	N/A	N/A
Hgb A1c	< or = 6.4 %	6.7 %	N/A	The hgb a1c is a measure of glucose control for the past 3 months. An elevated hgb a1c may indicate that the patient is not controlling their diabetes and may need insulin (Hinkle et al., 2022).
TSH	0.45 – 5.33 mlU/mL	1.38 mlU/ mL	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow, clear	Light yellow, clear	N/A	N/A
pH	5.0 – 9.0	8	N/A	N/A
Specific Gravity	1.005 – 1.025	1.047	N/A	High specific gravity suggests that the concentration of urine is a sign of dehydration (Hinke et al., 2022). Since the patient had diarrhea, the probability of having dehydration is high.
Glucose	Negative	Negative	N/A	N/A
Protein	Negative	Negative	N/A	N/A
Ketones	Negative	Negative	N/A	N/A
WBC	Negative	Negative	N/A	N/A
RBC	Negative	Negative	N/A	N/A
Leukoesterase	Negative	Negative	N/A	N/A

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35 – 7.45	7.45	N/A	N/A
PaO2	80 – 100 mmHg	93 mmHg	N/A	N/A
PaCO2	35 – 45 mmHg	40.7 mmHg	N/A	N/A
HCO3	21 – 28 mEq/L	28 mEq/L	N/A	N/A
SaO2	95 – 100 (%)	100 %	N/A	N/A

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	N/A
Blood Culture	Negative	Negative	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Hinkle, J.L., Cheever, K.H., & Overbaugh, K. (2022). *Brunner & suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.

Sarah Bush Lincoln Health Center (2022). *Laboratory Results.* Sarah Bush Lincoln Health

Center.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Electrocardiogram (9/21/2022): Shows signs of sinus arrhythmia and patient has a history of atrial fibrillation.

CT Angio of the brain/head with contrast (9/21/2022): This test showed an acute infarct to the left occipital and posterior lobe but showed no hemorrhage.

CT Angio of the neck with contrast (9/21/2022): This test showed moderate to severe short segment stenosis on the proximal right internal carotid at 70%.

X-ray of the chest (9/22/2022): Chest x-ray showed no signs of abnormalities.

Diagnostic Test Correlation (5 points):

Electrocardiogram: This is a standard test with patients admitted to the hospital.

CT Angio of the brain/head with contrast: This test is an imaging study of blood vessels in the key areas of the body like the brain. CT Angio uses computed tomography technology to examine the arteries and veins in the body. CT angiography confirms the diagnosis of an intracranial aneurysm or AVM. These tests show the location and size of the lesion and provide information about the affected arteries, veins, adjoining vessels, and vascular branch (Hinkle et al., 2022).

CT Angio of the neck with contrast: Neck CT can detect aneurysms, tumors, infections, thyroid nodules and other disorders associated with the neck region. In some cases, your doctor may order a neck CT with intravenous (IV) contrast. This allows for better visualization of blood vessels and other structures (Hinkle et al., 2022).

X-ray of the chest: In the absence of symptoms a chest x-ray may reveal an extensive pathologic process in the lungs. The routine chest x-ray consists of two views: the posteroanterior projection and the lateral projection. Chest x-rays are usually obtained after full inspiration because the lungs are best visualized when they are well alerted (Hinkle et al., 2022).

Diagnostic Test Reference (1) (APA):

Hinkle, J.L., Cheever, K.H., & Overbaugh, K. (2022). *Brunner & suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.

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

Home Medications (5 required)

Brand/Generic	Betapace/Sotalol	Katerzia/ Amlodipine	Prinivil/ Lisinopril	Potassium chloride	Rivaroxaban
Dose	80 mg	5 mg	20-25 mg	20 mEq	20 mg
Frequency	BID	Once daily	Once daily	Once daily	Once daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacologic: Nonselective beta blocker Therapeutic: Class III antiarrhythmic (Jones & Bartlett, 2020)	Pharmacologic: Calcium channel blocker Therapeutic: Antianginal, antihypertensive (Jones & Bartlett, 2020)	Pharmacologic: Angiotensin-converting enzyme (ACE) inhibitor Therapeutic: Antihypertensive (Jones &	Pharmacologic: Electrolyte cation Therapeutic: Electrolyte replacement (Jones & Bartlett, 2020)	Pharmacologic: Factor Xa inhibitor Therapeutic: Anticoagulant (Jones & Bartlett, 2020)

			Bartlett, 2020)		
Mechanism of Action	Combines class II and class III antiarrhythmic activity to increase sinus cycle length. Decreases AV nodal conduction and increases AV nodal refractoriness (Jones & Bartlett, 2020).	Binds to dihydropyridine and nondihydropyridine cell membrane receptor sites on myocardial and vascular smooth muscle cells and inhibits influx of extracellular calcium ions. This decreases diastolic and systolic blood pressure (Jones & Bartlett, 2020).	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II (Jones & Bartlett, 2020).	Acts as a major cation in intracellular fluid, activating many enzymatic reactions essential for physiologic processes, including nerve impulse transmission and cardiac and skeletal muscle contraction (Jones & Bartlett, 2020).	Selectively blocks the active site of factor Xa, which plays a central role in the cascade of blood coagulation. Without the action of factor Xa, blood clotting is impaired (Jones & Bartlett, 2020).
Reason Client Taking	History of atrial fibrillation	Hypertension	Hypertension	Hypokalemia precautions	Ischemic stroke
Contraindications (2)	Second or third degree AV block Heart failure (Jones & Bartlett, 2020)	Hypersensitivity to amlodipine and its components Hepatotoxicity (Jones & Bartlett, 2020)	Hereditary or idiopathic angioedema Concurrent aliskiren use in patients with diabetes (Jones & Bartlett, 2020)	Acute dehydration Concurrent use with amiloride or potassium sparing diuretics (Jones & Bartlett, 2020)	Active pathological bleeding Hypersensitivity to rivaroxaban or its components (Jones & Bartlett, 2020)
Side Effects/Adverse Reactions (2)	Bradycardia Hypotension (Jones & Bartlett, 2020)	Arrhythmias Hypotension (Jones & Bartlett, 2020)	CVA Bronchospasm (Jones & Bartlett, 2020)	Hyponatremic encephalopathy Anaphylaxis (Jones & Bartlett, 2020)	Subdural hematoma GI bleeding (Jones & Bartlett, 2020)
Nursing Considerations (2)	Expect to obtain baseline creatinine clearance and QT interval before starting this	Use amlodipine cautiously in patients with heart block, heart failure,	Be aware that lisinopril should not be given to a patient who is	Review a patient's medical history before administering	Should not be given to patients with moderate or severe hepatic impairment and to patients with

	medication and periodically throughout therapy, as ordered. Be aware that stopping sotalol abruptly may cause life-threatening reactions. (Jones & Bartlett, 2020)	impaired renal function, hepatic disorder, or severe aortic stenosis. Assess patients frequently for chest pain when starting or increasing the dose. (Jones & Bartlett, 2020)	hemodynamically unstable after an acute MI. Use lisinopril cautiously in patients with fluid volume deficit, heart failure, impaired renal function, or sodium depletion. (Jones & Bartlett, 2020)	potassium chloride, because there are many conditions that may predispose a patient to develop hyperkalemia. Administer oral potassium with or immediately after meals. (Jones & Bartlett, 2020)	a creatinine clearance that is less than 15 ml/min. Should not be given to patients at high risk of bleeding to prevent venous thrombosis. (Jones & Bartlett, 2020)
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor apical and radial pulses, blood pressure, circulation of the limbs, daily weight, fluid intake and output, and respiratory rate, before and during sotalol therapy (Jones & Bartlett, 2020).	Monitor patients with impaired hepatic function closely. Monitor blood pressure while adjusting dosage, especially in patients with heart failure or severe aortic stenosis because symptomatic hypotension may occur. (Jones & Bartlett, 2020)	Monitor blood pressure often, especially during the first 2 weeks of therapy and whenever the dose and/or prescribed diuretic is increased (Jones & Bartlett, 2020).	Electrolyte labs specifically potassium. Assess patients for signs of hypokalemia such as arrhythmias, fatigue, and weakness, and for signs of hyperkalemia, such as arrhythmias, confusion, dyspnea, and paresthesia. (Jones & Bartlett, 2020)	Monitor hepatic and renal function Monitor patients for risk factors for bleeding. (Jones & Bartlett, 2020)
Client Teaching Needs (2)	Advise patients to notify the provider immediately if they are experiencing shortness of breath. Urge patients to avoid hazardous activities until the	Tell patient to take missed dose as soon as remembered and next dose in 24 hours Tell the patient to immediately	Explain that lisinopril helps to control, but doesn't cure, hypertension and that patients may need lifelong	Advise patients to watch stools for changes in color and consistency and to notify prescriber if they become black, tarry, or	Instruct patient with atrial fibrillation to take the drug with the evening meal Emphasize the importance of taking rivaroxaban

	drug's CNS effects are known. (Jones & Bartlett, 2020)	notify the provider of dizziness, arm or leg swelling, difficulty breathing, hives, or rash. (Jones & Bartlett, 2020)	therapy. Advise patients to take lisinopril at the same time every day. (Jones & Bartlett, 2020**)**	red. Inform patients that potassium is part of a normal diet and that most meats, seafoods, fruits, and vegetables contain a sufficient amount of potassium. (Jones & Bartlett, 2020)	exactly as prescribed (Jones & Bartlett, 2020**)**

Hospital Medications (5 required)

Brand/Generic	Aspirin/Acetylsalicylic acid	Lipitor/ Atorvastatin calcium	Protonix/ Pantoprazole sodium	Colace/ Docusate sodium	NovoLog/Insulin aspart
Dose	81 mg	80 mg	40 mg	100 mg	Low dose sliding scale
Frequency	Q6H	Once daily	Once daily	BID	Sliding scale
Route	Oral	Oral	Oral	Oral	SubQ
Classification	Pharmacologic class: Salicylate Therapeutic: NSAID (anti-inflammatory, anti-platelet, antipyretic, nonopioid analgesic (Jones & Bartlett, 2020).	Pharmacologic class: HMG-CoA reductase inhibitor Therapeutic: Antihyperlipidemic (Jones & Bartlett, 2020)	Pharmacologic: Proton pump inhibitor Therapeutic: Antiulcer (Jones & Bartlett, 2020)	Pharmacologic: Surfactant Therapeutic:Laxative (Jones & Bartlett, 2020)	**Short-acting insulin**

Mechanism of Action	Aspirin inhibits platelet aggregation. Aspirin acts on the heat-regulating center in the hypothalamus and causes peripheral vasodilation, diaphoresis, and heat loss (Jones & Bartlett, 2020).	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown (Jones & Bartlett, 2020).	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine-triphosphatase enzyme system, or proton pump, in gastric parietal cells (Jones & Bartlett, 2020).	Acts as a surfactant that softens stool by decreasing surface tension between oil and feces. This action lets more fluid penetrate stool, forming a softer fecal mass (Jones & Bartlett, 2020).	Insulin aspart regulates the metabolism of glucose. It promotes the storage and inhibits the breakdown of glucose, fat, and amino acids. Insulin lowers blood glucose by increasing peripheral glucose uptake, particularly in the skeletal muscle and fat (Jones & Bartlett, 2020).
Reason Client Taking	Ischemic stroke for the antiplatelet effect	Hyperlipidemia	GERD	Constipation	Diabetes type II
Contraindications (2)	Active bleeding Coagulation disorders (Jones & Bartlett, 2020)	Active hepatic disease Unexplained persistent rise in serum transaminase level (Jones & Bartlett, 2020**)**	Concurrent therapy with rilpivirine-containing products Hypersensitivity to pantoprazole (Jones & Bartlett, 2020)	Intestinal obstruction Nausea, vomiting, or other symptoms of appendicitis (Jones & Bartlett, 2020)	Hypoglycemia Hypersensitivity to insulin and its components (Jones & Bartlett, 2020)
Side Effects/Adverse Reactions (2)	CNS depression Hepatotoxicity (Jones & Bartlett, 2020)	Arrhythmias Hypoglycemia (Jones & Bartlett, 2020)	C-diff associated diarrhea Hepatotoxicity (Jones & Bartlett, 2020)	Abdominal pain and distention Dizziness/ syncope (Jones & Bartlett, 2020)	Hypoglycemia Tachycardia (Jones & Bartlett, 2020)
Nursing Considerations (2)	Don’t crush timed-release or controlled-release aspirin tablets unless directed.	Use atorvastatin cautiously in patients who consume substantial	Monitor patient’s urine output because this medication	Expect excessive or long-term use of docusate to cause	Check the patient’s medical history for kidney disease, heart disease, and beta blocker

	Ask about tinnitus. This reaction usually occurs when blood aspirin level reaches or exceeds maximum dosage. (Jones & Bartlett, 2020)	quantities of alcohol or have a history of liver disease. Monitor diabetic patient's blood glucose levels because atorvastatin therapy can affect blood glucose control. (Jones & Bartlett, 2020)	can cause acute interstitial nephritis. Notify prescriber if urine output decreases or there is blood in the urine. Monitor patients for bone fracture, especially in patients receiving multiple daily doses for more than a year because proton pump inhibitors increase the risk of osteoporosis-related fractures of the hip, spine, or wrist. (Jones & Bartlett, 2020)	dependence on laxatives for bowel movements, electrolyte imbalances, osteomalacia, steatorrhea, and vitamin and mineral deficiencies. Assess for laxative abuse syndrome. (Jones & Bartlett, 2020)	therapy. Check the patient's diagnosis and how it relates to the administration of insulin. (Jones & Bartlett, 2020)
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Hepatic function labs Coagulation studies (Jones & Bartlett, 2020)	Hepatic function labs Lipid levels Blood glucose (Jones & Bartlett, 2020)	Monitor patients for diarrhea from C. difficile which can occur with or without antibiotics in patients taking this medication.	Electrolyte labs Assess for laxative abuse syndrome (Jones & Bartlett, 2020)	Monitor the patient's blood glucose levels, food intake, and physical activity (Jones & Bartlett, 2020).

			(Jones & Bartlett, 2020)		
Client Teaching Needs (2)	Patients should take aspirin with food or after meals because it may cause GI upset if taken on an empty stomach. Advise patients to avoid alcohol while taking aspirin to decrease risk of ulcers. (Jones & Bartlett, 2020)	The patient should take the drug at the same time each day to maintain effects. If the patient misses a dose, instruct the patient to take the missed dose as soon as possible. If it's almost time for the next dose, skip the dose. Don't double the dose. (Jones & Bartlett, 2020)	Instruct the patient to swallow tablets whole and not to chew or crush them. Warn patients not to exceed dosage or take longer than prescribed, as long-term use increases risk of serious adverse reactions. (Jones & Bartlett, 2020)	Tell patients not to use this medication when they have abdominal pain, nausea, or vomiting. Advise patients to take docusate with a full glass of milk or water. (Jones & Bartlett, 2020)	Ensure that the patient rotates injection sites when they are self administering the insulin. Encourage the patient to avoid alcohol intake, or at least 1 to 2 units per day while taking insulin. (Jones & Bartlett, 2020)

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is A/O x2 and is oriented to self and place. The patient is not in any distress currently. Patient's overall appearance is within expected range under the circumstances.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Patient's skin is pink, warm, and dry. Patient's skin turgor is elastic and shows no signs of abnormality. The patient does not have any rashes, bruises, and wounds. The patient's Braden score is 19 and does not show any signs of pressure ulcers. The patient does not have any drains present at this moment.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normocephalic with no wounds, bruises, or rashes. The patient's trachea is midline. The patient's ear is equal and shows no signs of excessive cerumen. Patient does have difficulty hearing, but does not wear any hearing aids. Patient exhibits PERLA. The patient's nose is midline and is dry and patent in the nares. The teeth are WDL and the patient's mucous membranes are moist and pink.
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:**	Radial pulses are 3+. The S1 and S2 are present with no signs of S3, S4, or murmurs. However, the patient's heart sounds are slightly irregular. The peripheral pulses are all within expected range. The capillary refill is also with expected range with less than 3 seconds. The patient isn't showing any signs of neck vein distention and edema. The patient's EKG shows sinus arrhythmia.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒**	Airway is patent with no signs of change in clinical course. Breathing is clear and equal

Breath Sounds: Location, character	bilaterally in all lobes.
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:**	Diet at home is unknown. Current diet is regular/thin. Patient's height is 178 cm. Patient's weight is 70 kg. Upon auscultation, the bowel sounds are all present in all quadrants. Patient's last bowel movement was 9/26/2022. Upon palpation, abdomen is soft with no abnormalities. No signs of distention, incisions, wounds, or scars. The patient does not have any drains present at this moment. The patient does not have an ostomy bag, NG tube, or feeding tube at this moment.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: Acute foley catheter** **Size: French 16**	The patient's urine is within expected range. The patient does not report any pain urinating, and the patient is currently not on dialysis. Patient had a catheter in place for retention and was removed during the clinical course.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 75** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	The patient's neurovascular status is within expected range. The patient can move all extremities equally. The patient needs a walker and gait belt for ambulation. Upon standing up, the patient is shaky and shows some weakness. Needs assistance. The patient's fall score is 75 which puts him at risk.
NEUROLOGICAL:	The patient can move all extremities equally.

MAEW: Y ☒ N☐ **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient shows signs of PERLA. The patient is A/O x2, denies any numbness or tingling. The patient's speech is garbled due to the stroke. The patient's sensory skills are intact. The patient's level of consciousness is intact.
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):**	The patient states religion is his coping method. The patient has acquired a bachelor's degree and is currently retired. The patient is catholic and says he uses it for comfort. The patient lives alone.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0738	68 bpm	141/77 left arm	18 breaths/min	37.3 C tympanic	96% Room air
1100	70 bpm	135/75 left arm	18 breaths/min	37.3 C tympanic	96% Room air

Vital Sign Trends: The patient's blood pressure went down due to the hypertension medications that were given at the 0900 medication pass. All other vital signs are steady and have not changed.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0858	Numeric	N/A	0/10	N/A	N/A
1000	Numeric	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Left: 20 G Right: 18 G **Location of IV:** Left forearm, Right AC **Date on IV:** Left: 9/21/22 Right: 9/21/22 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** N/A **IV dressing assessment:** Dry, intact, patent	Saline lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL (milk 2%) – 9/26/22	1,425 mL (urine) – 9/26/22 Stool x3

Nursing Care

Summary of Care (2 points)

Overview of care: The patient got his vital signs done at 0700 and got his daily medications around 0900. The patient got his urinary foley catheter removed around 1000. The patient was visited by physical therapy and speech therapy to discuss next steps and his process.

Procedures/testing done: The patient did not have any procedures or testing done during the clinical course.

Complaints/Issues: The patient had no complaints regarding his condition.

Vital signs (stable/unstable): The patient had stable vital signs throughout the clinical course.

Tolerating diet, activity, etc.: The patient is tolerating diet and needs help with activities such as going to the bathroom and getting out of bed.

Physician notifications: Referral to Dr. Green for the carotid stenosis

Future plans for client: The patient will follow up with speech therapy and PT/OT

Discharge Planning (2 points)

Discharge location: Hilltop nursing home

Home health needs (if applicable): N/A

Equipment needs (if applicable): The patient will need a walker or a type of assistive walking device and the CPAP/BiPAP.

Follow up plan: The patient will follow up with a neurology clinic in one month or sooner.

Education needs: The patient will be educated regarding the ischemic stroke and preventative measures.

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 ● Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** ● Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** ● How did the client/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
Risk for aspiration related to difficulty swallowing as evidenced by	This nursing diagnosis was chosen because the patient's gross/	1. Crushing medication into pudding with assisted feeding	1. Ensure that the patient is monitored during meals with assisted	The patient showed no signs of choking or distress when fed the medication and pudding mixture.

spontaneous drooling	fine motor skills are affected by the stroke.	2. Drinking water with a straw	feeding	Patient has no concerns at this time.
Acute confusion related to brain infarction as evidenced by A/O x2.	This nursing diagnosis was chosen because the patient's stroke has him confused about the time and sometimes the place.	1. Supporting the patient and celebrating small wins to give the patient confidence. 2. Collaborating with the interprofessional team such as speech and PT/OT.	1. Ensure that the patient is being supported and to help the patient with activities of daily living	The patient's orientation is A/O x2 and will continue to support the patient with activities of daily living. The patient stated that his sessions with speech and PT/OT "Went alright."
Impaired verbal communication related to brain damage as evidenced by garbled speech and speaking one to two word sentences.	This diagnosis was chosen because the difficulty with communicatio n can hinder his care since he isn't able to communicate how he feels and what may be helping him	1. Using different forms of communication such as hand gestures. 2. Collaborating with the interprofessional team such as speech therapy.	1. Improvement of speech and mobility	The patient went through the speech therapy session and the patient stated that everything "went alright." The patient is trying to communicate in other means by pointing at objects that he wants or needs.
Risk for impaired skin integrity related to decreased mobility as evidenced by weakness and being unable to support one's self	This diagnosis was chosen because if the skin integrity gets impaired the patient will be at risk for infection.	1. Using powder inside of the flaps of the skin to protect the barrier. 2. Changing positions every 2 hours.	1. Lower the risk of the patient getting a pressure ulcer.	The patient is getting the powder administered when needed and the patient is also getting turned every 2 hours as planned. The patient has no signs of impaired skin during this clinical course**.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

73 year old male presented to the ED with altered mental status.
The patient is a former smoker and drinks beer, wine, and liquor 1-2x week.

Nursing Diagnosis/Outcomes

Risk for aspiration related to difficulty swallowing as evidenced by spontaneous [illegible]ling
Ensure that the patient is monitored during meals with assisted feeding
Acute confusion related to brain infarction as evidenced by A/O x2.
Ensure that the patient is being supported and to help the patient with activities of daily living
Impaired verbal communication related to brain damage as evidenced by garbled speech and speaking one to two word sentences.
Improvement of speech and mobility
Risk for impaired skin integrity related to decreased mobility as evidenced by weakness and being unable to support one's self
Lower the risk of the patient getting a pressure ulcer.

Objective Data

Abnormal labs include: platelets, glucose, creatinine, bilirubin, INR, PT, hemoglobin A1c, and urine specific gravity.
Vital signs: Showed slight hypertension.
Assessment: The patient is A/Ox2 and the speech is garbled. The patient is also showing signs of weakness and is suffering urinary retention. The patient's heart sounds were also irregular with the EKG showing a sinus arrhythmia.

Client Information

[illegible]esented to the ED on 9/21/2022 with altered mental status. Patient was not seen for two days, and the landlord found him with garbled speech. CT of the head shows acute infarct of the left occipital and posterior temporal lobe and showed no hemorrhage. The CTA of the neck shows moderate to severe short segment stenosis proximal to the right internal carotid 70%. Neurology will come for a consultation before discharge.

Nursing Interventions

Crushing medication into pudding with assisted feeding
Drinking water with a straw
Supporting the patient and celebrating small wins to give the patient confidence.
Collaborating with the interprofessional team such as speech and PT/OT.
Using different forms of communication such as hand gestures.
Collaborating with the interprofessional team such as speech therapy.
Using powder inside of the flaps of the skin to protect the barrier.
Changing positions every 2 hours.