

N441 Care Plan

Lakeview College of Nursing

Sophia James

Demographics (3 points)

Date of Admission 3/22/2023	Client Initials DH	Age 84	Gender Male
Race/Ethnicity African American	Occupation Retired	Marital Status Married	Allergies No known allergies
Code Status Full	Height 5'10" 177.8cm	Weight 112kg 247lbs	

Medical History (5 Points)**Past Medical History:**

Chronic hypertension 1/29/2020, Bowel obstruction 5/12/2020, Stage 3 chronic kidney disease 8/28/2022, Chronic Diastolic CHF 8/28/2022

Past Surgical History:

Exploratory of Abdomen, Appendectomy, Upper right arm, and elbow surgery

Family History:

Mother has a history of hypertension and heart disease.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use):

The patient denies use of tobacco and other drugs. The patient states that he drinks alcohol twice a week socially.

Assistive Devices:

The patient uses a walker to get around at home.

Living Situation:

The patient lives at home with his wife.

Education Level:

The patient graduated high school and is retired. No developmental delays present.

Admission Assessment

Chief Complaint (2 points):

Abdominal pain 3/22/23 is the original admission date for bowel obstruction.

History of Present Illness – OLD CARTS (10 points):

The patient is an 84-year-old male brought into the ED by his wife and caretaker with generalized abdominal pain. The patient has a history of colon cancer with post-hemicolectomy complications. The patient has not been able to pass gas for the past 12 hours and has not had a BM in the past 24 hours. The patient stated they vomited on 3/21/2023. The patient's pain is intermittent and diffused through the abdomen. The patient's abdomen is distended upon inspection. The patient states there are no relieving factors and has not tried to treat them himself.

Primary Diagnosis**Primary Diagnosis on Admission (2 points):**

3/22/2023 ED- Bowel obstruction with AKI

Secondary Diagnosis (if applicable):

3/26/2023 Upon discharge from the ED, the patient suffered a stroke (CVA) and was sent up to the ICU.

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

CVA aka Stroke

A stroke happens when blood flow is lost to a specific part of the brain, and one's brain cells cannot get the oxygen and nutrients they need from blood. This can cause lasting brain damage, long-term disability, or even death. Another condition similar to a stroke is a transient ischemic attack or a TIA. TIA's are sometimes called a "mini-stroke." TIAs happen when the

blood supply to the brain is blocked for a short time but does not damage the brain cells permanently.

Risk factors for stroke include hypertension, heart disease, atrial fibrillation, smoking, family history, and diabetes. Signs and symptoms include trouble speaking, weakness of one side of the body, difficulty walking, trouble to see, severe headaches, loss of coordination, or a new onset of confusion. The way a PCP will diagnose a stroke is by doing a background history assessment on the patient and doing a physical exam. If there is an expected stroke, the provider will order imaging tests to view the brain, such as a CT scan. Treatment for a stroke includes tPA, a tissue plasminogen activator to help dissolve any possible clot that caused the stroke (National Institute of Neurological Disorders and Stroke, 2021). The provider might also want the patient to be on a blood thinner to keep existing clots from getting more significant. Patients may also see physical rehab therapy to regain their strength on their weakened side.

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis]. Retrieved from <https://fadavisreader.vitalsource.com/#/books/9781719641470/>

National Institute of Neurological Disorders and Stroke. (2021, May 5). *Stroke, CVA, Cerebrovascular accident*. MedlinePlus: Health Information from the National Library of Medicine. <https://medlineplus.gov/stroke.html#summary>

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	4.90	4.15	This value is low due to the body recovering from the CVA (Capriotti, 2020).
Hgb	13.0-16.5	13.6	11.5	This value is low due to the body recovering from the CVA (Capriotti, 2020).
Hct	38%-50%	43.3	36.8	This value is low due to the body recovering from the CVA (Capriotti, 2020).
Platelets	140-440	349	258	This value is within the normal limits.
WBC	4-12	15.60	14.80	This patients WBC count was high which indication inflammation or a bacterial infection (Capriotti, 2020).
Neutrophils	40-68	82.2	74.6	Neutrophils are increased due to a sign of inflammation in the body or increased healing process (Capriotti, 2020).
Lymphocytes	19-49	6.9	15.8	The patients lymphocytes are elevated related to the body's response from the infection and healing process (Capriotti, 2020).
Monocytes	3-13	10.8	7.9	This value is within the normal limits.
Eosinophils	0-8	0	1.3	This value is within the normal limits.
Bands	0-5	0	0	This value is within the normal limits.

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	136	136	This value is within the normal limits.
K+	3.5-5.0	5.0	3.7	This value is within the normal limits.
Cl-	98-107	103	107	This value is within the normal limits.
CO2	22-30	14	18	The patient's CO2 levels are low due to the increase work of breathing
Glucose	70-99	152	98	This patient's glucose is elevated

				due to his body having extra stress on it (Capriotti, 2020).
BUN	8-26	79	17	The patients BUN is elevated due to the patient coming into the ED with abnormal Urine cultures.
Creatinine	0.70-1.30	3.93	1.56	The patient's creatinine is elevated due to the patient coming into the ED with abnormal Urine cultures.
Albumin	3.5-5.0	4.2	3.5	This value is within the normal limits.
Calcium	8.7-10.5	10.2	8.7	This value is within the normal limits.
Mag	1.6-2.6	None taken	None taken	This value was not taken.
Phosphate	40-150	119	80	This value is within the normal limits.
Bilirubin	0.2-1.2	0.6	0.4	This value is within the normal limits.
Alk Phos	40-150	119	80	This value is within the normal limits.
AST	5-34	18	28	This value is within the normal limits.
ALT	0-55	13	31	This value is within the normal limits.
Amylase	40-140	None taken	None taken	This value was not taken.
Lipase	0-160	None taken	None taken	This value was not taken.
Lactic Acid	<2	None taken	None taken	This value was not taken.
Troponin	0-0.040	<0.030	None taken	This value is within the normal limits.
CK-MB	3-5%	None taken	None taken	This value was not taken.
Total CK	55-170	None taken	None taken	This value was not taken.

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

Lab Test	Normal	Value on	Today's	Reason for Abnormal
----------	--------	----------	---------	---------------------

	Range	Admission	Value	
INR	0.8-1.1	1.0	None taken	This value is within the normal limits.
PT	10.1-13.1	11.6	None taken	This value is within the normal limits.
PTT	25-36	35	None taken	This value is within the normal limits.
D-Dimer	<0.50	None taken	None taken	This value was not taken.
BNP	<100	None taken	None taken	This value was not taken.
HDL	>40	None taken	29	This value is within the normal limits.
LDL	<130	None taken	55	This value is within the normal limits.
Cholesterol	<200	100	101	This value is within the normal limits.
Triglycerides	<150	None taken	85	This value is within the normal limits.
Hgb A1c	<5.7%	None taken	None taken	This value was not taken.
TSH	0.5-5.0	None taken	None taken	This value was not taken.

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 pale	Cloudy and yellow	None taken	The patient came into the ED with AKI which would cause these abnormal labs.
pH	5-9	5.0	None taken	This value is within the normal limits.
Specific Gravity	1.003-1.030	1.021	None taken	This value is within the normal limits.
Glucose	negative	negative	None taken	This value is within the normal limits.
Protein	negative	+1	None taken	The patient came into the ED with AKI which would cause these abnormal labs.
Ketones	negative	positive	None taken	The patient came into the ED with AKI which would cause these abnormal labs.

WBC	negative	positive	None taken	The patient came into the ED with AKI which would cause these abnormal labs. The patient could have a possible UTI that led to this AKI.
RBC	negative	negative	None taken	This value is within the normal limits.
Leukoesterase	negative	negative	None taken	This value is within the normal limits.

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

No ABG's were found in the client's records or chart.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.35	N/A	N/A	This value was not taken.
PaO2	80-100	N/A	N/A	This value was not taken.
PaCO2	35-45	N/A	N/A	This value was not taken.
HCO3	22-26	N/A	N/A	This value was not taken.
SaO2	90-100%	N/A	N/A	This value was not taken.

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	Positive	negative	The patient came into the ED with AKI which would cause these abnormal labs. The patient could have a possible UTI that led to this AKI.

Blood Culture	Negative	negative	negative	This finding is not abnormal.
Sputum Culture	Negative	negative	negative	This finding is not abnormal.
Stool Culture	Negative	negative	negative	This finding is not abnormal.

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT head and neck without contrast 3/27/23

Stroke follow-up –

- No new aneurysms noted
- Hypodensity noted in the left occipital lobe

MRI brain without contrast 3/27/23

- Showed an area of restricted diffusion in the left posterior occipital
- No hemorrhage noted

Diagnostic Test Correlation (5 points):

This patient suffered a CVA while leaving the hospital on 3/26/2023. The patient scans returned with no aneurysms or hemorrhage, but a small portion of his left occipital lobe had restricted diffusion of the rest.

Diagnostic Test Reference (1) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis]. Retrieved from <https://fadavisreader.vitalsource.com/#/books/9781719641470/>

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Elsevier.

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

Home Medications (5 required)

Brand/Generic	Acetaminophen Tylenol	Labetalol Normodyne	Ondansetron Zofran	Sodium Salicylate Aspirin	There were no more medications listed in that patient's MAR.
Dose	650mg	10mg	4mg	81mg	N/A
Frequency	Q6hr PRN	Q1hr PRN	Q6hr	Every evening	N/A
Route	Oral	IV	IV	Oral	N/A
Classification	Non-opioid analgesic	Non-opioid analgesic	Serotonin receptor agents	Non-steroid anti-inflammatory	N/A
Mechanism of Action	Blocks the prostaglandin production and interferes with pain	This drug relaxes the blood vessels and slows the heart rate down to	Zofran blocks the action of serotonin that reduces the cause of	Inhibits enzyme COX by inhibiting the prostaglan	N/A

	impulses generated by the peripheral nervous system	improve blood flow and decrease the BP.	vomiting and nausea.	din synthesis which is associated with inflammation and pain.	
Reason Client Taking	Pain control	Control hypertension	Nausea and vomiting	pain	N/A
Contraindications (2)	Hypersensitivity to acetaminophen or its components, severe hepatic impairment, severe active liver disease	This medication is contraindicated for patient's with severe bradycardia and bronchial asthma.	Do not give this medication if the patient has low amounts of calcium in the blood. Do not give if the client is experiencing extrapyramidal disease.	Do not give to children due to cause of Reye's syndrome. Do not give if the patient has any bleeding abnormalities.	N/A
Side Effects/Adverse Reactions (2)	Hypotension, hepatotoxicity, hypomagnesium	Sleepiness and headache	Constipation drowsiness	Abdominal pain, ringing in ears, bloody or black tarry stools.	N/A
Nursing Considerations (2)	Use acetaminophen cautiously and patience with hepatic impairment or active hepatic diseases, alcoholism, chronic malnutrition, severe hypovolemia,	The nurse should monitor the clients BP and heart rate while giving this medication. The client should watch for signs of respiratory distress.	Administer this medication slowly into the IV. Respiratory status must be checked prior.	Monitor the patients CBC and H&H. Monitor clotting times if they are at risk for bleeding.	N/A

	or severe renal impairment.				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	The nurse should monitor the patients CBC prior to administering this medication.	The nurse should ALWAYS check the patients pulse rate prior to giving this medication.	Check respiratory status and monitor EKG	Monitor blood clotting times.	N/A
Client Teaching needs (2)	Educate the client on effects of taking too much. Teach the client to take food with this drug if it causes stomach upset.	The client should watch for signs of respiratory distress and severe bradycardia.	Do not take this medication if you do not absolutely need it. The first dose is usually always given before starting chemo or radiation treatment.	Do not give this medication to children. Do not take this medication if you are experiencing bloody stools or bloody emesis.	N/A

Hospital Medications (5 required)

Brand/Generic	Furosemide Lasix	Aspirin Suppository	There were no more medications listed in that patient's MAR.	There were no more medications listed in that patient's MAR.	There were no more medications listed in that patient's MAR.
Dose	40 mg	300 mg	N/A	N/A	N/A

Frequency	2 daily with meals	Every evening	N/A	N/A	N/A
Route	oral	rectal	N/A	N/A	N/A
Classification	Diuretic	NSAIDS	N/A	N/A	N/A
Mechanism of Action	Inhibits the reabsorption of sodium and chloride from the renal system.	Inhibits enzyme COX by inhibiting the prostaglandin synthesis which is associated with inflammation and pain.	N/A	N/A	N/A
Reason Client Taking	Can help treat high blood pressure but also removes fluid from the body.	Bowel Obstruction	N/A	N/A	N/A
Contraindications (2)	Hypersensitivity to furosemide. Monitor for hepatic cirrhosis or ascites.	Do not give to the patient if they have any rectal bleeding or nausea and vomiting.	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	Loss of appetite, blurred vision.	Bloody vomit Black tarry stools	N/A	N/A	N/A
Nursing Considerations (2)	Monitor blood pressure and oliguria	Hepatitis and severe hepatic or renal failure are huge considerations for nurses to consider.	N/A	N/A	N/A
Key Nursing Assessment(s)/Lab(s) Prior to	Monitor serum glucose and uric acid	Monitor the client's pain before and	N/A	N/A	N/A

Administration	levels before administration.	after the suppository.			
Client Teaching needs (2)	Educate the patient on frequent urination and the possible need of supplemental electrolytes.	Teach the client to monitor for any rectal bleeding and monitor for signs and symptoms or dizziness or nausea.	N/A	N/A	N/A

(Jones & Bartlett Learning, 2022).

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2022). *2022 Nurse's Drug Handbook* (20th ed.).

Assessment

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

GENERAL: Alertness: Orientation: Distress: Overall appearance:	The patient is alert and oriented x2. The patient appears to be in no distress and his overall appearance is swollen, but comfortable.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 13 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	The patient's skin was dry and intact with slight bruising on his arms from previous puncture sites. Skin turgor is quick to return. No rashes, wounds, or tears. No drains are present.
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	Head is symmetrical with neck. Slight right sided drooping is noted in the client's face. When the client is instructed to smile, they can only smile on the left side.

<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>No murmur or abnormal heart rate. Peripheral pulses palpable, doppler used for right leg pulse. Generalized edema in all extremities +2. Right arms and legs +3 edema. Capillary refill <3 seconds bilaterally.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p> <p>ET Tube: None Size of tube: Placement (cm to lip): Respiration rate: FiO2: Total volume (TV): PEEP: VAP prevention measures:</p>	<p>Respiration rate was high at 24 breaths per minute. Lung sounds were clear bilaterally. Accessory muscle use was noted upon assessment. No ET tubes.</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: 3/25/23 Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>The patient eats a normal diet. All bowel sounds were heard in all 4 quadrants. The patient had no pain with palpitation of the abdomen. The abdomen is slightly distended but not tender. No wounds or drains are noted.</p>
<p>GENITOURINARY: Color:</p>	<p>The patient used a urinal independently. Upon assessment the urine was amber. There was no</p>

<p>Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size: CAUTI prevention measures:</p>	<p>pain with urination. Output- 475ml.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: +2 ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 54 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input checked="" type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/></p>	<p>The patient active ROM was present but limited and needed to be reminded on what extremity to move. The patient uses a walker to stand and walk. Chair fast with assistance in standing and ambulating.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>The patient presented with right sided weakness in both upper and lower extremities. The patient was oriented x2 to person and situation. The patient showed no speech or sensory disruptions.</p>
<p>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):</p>	<p>The client is A&O x 2. The client’s wife was at the bedside. No developmental delays were noted. The patient lives at home with his wife.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1000	91	152/89	19	98.1	98%

1300	108	173/87	30	97.9	98%
------	-----	--------	----	------	-----

Vital Sign Trends/Correlation:

1000 – patient’s blood pressure is high, but he received his BP medication at this time.

1300 – patient's vital signs were taken during a therapy session, explaining the elevation.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	Numeric	Denies Pain	0	None	None Needed
1300	Numeric	Denies Pain	0	None	None Needed

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g Location of IV: L AC Date on IV: 3/26/23 Patency of IV: flows easily Signs of erythema, drainage, etc.: None IV dressing assessment: Dry and intact	Dextrose 5% solution 100ml/hr IV continuous
Other Lines (PICC, Port, central line, etc.):	None noted
Type: Size: Location: Date of insertion: Patency: Signs of erythema, drainage, etc.: Dressing assessment: Date on dressing: CUROS caps in place: Y <input type="checkbox"/> N <input type="checkbox"/> CLABSI prevention measures:	No other lines or drains noted.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
-----------------------	-----------------------

720ml PO	475ml urine

Nursing Care

Summary of Care (2 points)

Overview of care:

The client was very cooperative and active in care. The patient was A&O x2 to person and situation. Not to place or time. The patient is being monitored and continuing with orders for physical therapy.

Procedures/testing done:

The patient had an MRI and CT of the brain/head on 3/26. No procedures were done today.

Complaints/Issues:

The patient was cooperative and calm while explaining care. There were no signs of pain or discomfort during care.

Vital signs (stable/unstable):

Unstable due to hypertension and therapy sessions.

Tolerating diet, activity, etc.:

Tolerating diet well, tolerating activity in moderation. The patient needs stand-by commands for moving extremities, and one person assist for sitting up and ambulating.

Physician notifications:

Continue with care until more strength returns to the client’s right side.

Future plans for client:

The future plans for the client include discharging to OSF PT rehab facility to work on strength and coordination for the patient's right side.

Discharge Planning (2 points)

Discharge location: OSF rehab in Urbana

Home health needs (if applicable): physical therapy/home checks.

Equipment needs (if applicable): Walker

Follow up plan: continue with physical therapy and speech therapy.

Education needs: The patient will need post-CVA education on future signs to look for.

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
<ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components • Listed in order by priority – highest priority to lowest 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 			<ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client response, status of goals and outcomes,

priority pertinent to this client				modifications to plan.
<p>1. Acute pain related to constipation as evidenced by cramping, stomach upset, and no passing of flatus.</p>	<p>This nursing diagnosis was picked due to the fact the patient come into the ED with abdominal pain and not having a BM for 24 hours.</p>	<p>1. Assess for pain before and after pain medications are given</p> <p>2. Assess bowel sounds and the presence of passing gas.</p>	<p>1. The patient will express less pain and less abdominal distention.</p>	<p>The nurse should assess to see if the patient passed gas or had a bowel movement.</p>
<p>2. Imbalanced nutrition related to altered absorption as evidenced by CBC and electrolytes being abnormal.</p>	<p>This patient had a decrease of protein and electrolytes in his body due to coming into the ED with AKI and Bowel Obstruction.</p>	<p>1. The nurse should assess the patient's CBC and lab values when they are submitted into their chart.</p> <p>2. The nurse should have strict I&Os on this client.</p>	<p>1. The patient's lab values and electrolytes will return to normal, and the patient will show adequate intake and output.</p>	<p>The nurse should assess to see if the patient has any signs of malabsorption of their intake.</p>
<p>3. Risk for falls related to right sided weakness.</p>	<p>This patient is at a risk for falling due to their recent stroke and right sided weakness.</p>	<p>1. The nurse should preform active and passive ROM with the client.</p> <p>2 The nurse should assess for any pain or trouble moving his Right sided extremities.</p>	<p>1. The patient will have full range of motion back in their right side without needing commands.</p>	<p>The client will experience no falls when gaining full strength back.</p>
<p>4. Self-care</p>	<p>This</p>	<p>1. The nurse</p>	<p>1. The</p>	<p>The patient</p>

<p>deficit related to loss of muscle strength as evidenced by difficulty doing ADLs.</p>	<p>diagnosis was chosen by the student due to the fact that the patient has right sided weakness and is having trouble performing daily tasks without assistance.</p>	<p>should encourage the client to perform as many tasks as possible on their own.</p> <p>2. The nurse should always give positive feedback when the patient does any sort of self-care.</p>	<p>patient is able to assess the needs for help and asks for self-care assistance when needed.</p>	<p>recognizes when they need help and is able to assist in the daily help with the care giver.</p>
<p>5. Risk for unilateral neglect related to right sided weakness.</p>	<p>The student chose this diagnosis due to patient suffering a stroke and having right sided weakness. The patient is right-handed so he might start to favor his left side more now due to this weakness.</p>	<p>1. The nurse should encourage movement and activity on the weakened side.</p> <p>2. The nurse should assess for signs of unilateral neglect such as the client laying awkwardly to avoid hurting one side.</p>	<p>1. The patient shows interest in using his weakened side more often on his own without being commanded to.</p>	<p>The patient performs task with his right side and performs active ROM with all extremities.</p>

Other References (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis]. Retrieved from <https://fadavisreader.vitalsource.com/#/books/9781719641470/>

Concept Map (20 Points)

Subjective Data

The patient has not been able to pass gas for 12 hours or have a bowel movement for 24 hrs. The patient's abdominal pain is diffused though his abdomen. The patient stated he was in no pain after the stroke but this right arm was more swollen to him.

Objective Data

The patient has right sided weakness, drooping, and swelling. The patient's neuros are all intact besides being A&O x 2. The patient has had a bowel obstruction in the past after a post-hemicolectomy. Vitals: pulse 91, BP 152/89, Temp 98.1, Respirations 19, O2 98%.

Client Information

84-year-old male.
 Chronic hypertension 1/29/2020,
 Bowel obstruction 5/12/2020,
 Stage 3 chronic kidney disease 8/28/2022,
 Chronic Diastolic CHF 8/28/2022

 Weight: 112kg. height: 5'10"
 Lives at home with his wife

Nursing Diagnosis/Outcomes

- Acute pain related to constipation as evidenced by cramping, stomach upset, and no passing of flatus.**
 - The patient will express less pain and less abdominal distention.
- Imbalanced nutrition related to altered absorption as evidenced by CBC and electrolytes being abnormal.**
 - The patient's lab values and electrolytes will return to normal, and the patient will show adequate intake and output.
- Risk for falls related to right sided weakness.**
 - The patient will have full range of motion back in their right side without needing commands.
- Self-care deficit related to loss of muscle strength as evidenced by difficulty doing ADLs.**
 - The patient is able to assess the needs for help and asks for self-care assistance when needed.
- Risk for unilateral neglect related to right sided weakness.**
 - The patient shows interest in using his weakened side more often on his own without being commanded to.

Nursing Interventions

- Assess bowel sounds and the presence of passing gas.
- The nurse should have strict I&Os on this client.
- The nurse should perform active and passive ROM with the client.
- The nurse should assess for any pain or trouble moving his Right sided extremities.
- The nurse should encourage movement and activity on the weakened side.
- The nurse should assess for signs of unilateral neglect such as the client laying awkwardly to avoid hurting one side.
- The nurse should encourage the client to perform as many tasks as possible on their own.
- The nurse should always give positive feedback when the patient does any sort of self-care.

