N321 CARE PLAN #2

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Lakeview College of Nursing

N321: Adult Health I

Professor Henry

02/14/24

Demographics

Date of Admission	Client Initials	Age	Biological Gender
2-09-24	T.J.S	62	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/ non-Hispanic	Unemployed	Married	No known allergies
Code Status	**Height**	**Weight**	
Full code	190.5cm	105kg	

Medical History

Past Medical History: Patient has a past medical history of anxiety, hypertension, umbilical hernia, acute arterial ischemic stroke.

Past Surgical History: Patient has a past surgical history of colonoscopy, left-hand surgery, hernia repair, upper gastrointestinal endoscopy.

Family History: The patient has a family history of stomach cancer, both from their mother and maternal grandmother.

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

The patient has a social history of 1 pack/day of cigarettes for 20 years, 1 drink of alcohol once a month for 40 years, they have occasional marijuana use at once a month for 40 years.

Education: The patient currently holds a high school diploma.

Living Situation: The patient currently lives locally with their wife.

Assistive devices: The patient does not use any assistive devices.

Admission History

Chief Complaint: The patient came in complaining of a headache.

History of Present Illness (HPI)– OLD CARTS

The patient came into the emergency room complaining of a headache lasting over 12 hours. They say the pain started sometime between the night of 02/08 and the early morning of 02/09. The headache is causing increasing weakness in the left-sided extremities. The patient states the pain as "5 out of 10" on a pain scale of 0 to 10. The pain is exacerbated by coughing. They have been using rest for relief and trying to treat it with acetaminophen with no relief.

Admission Diagnosis

Primary Diagnosis: CVA

Secondary Diagnosis (if applicable): N/A

Pathophysiology

The brain is the most energy-consuming organ in the body, using 20% of the body's oxygen (Capriotti, 2024). Lack of cerebral blood flow causes cerebral hypoxia, which can cause brain dysfunction; a lack of oxygen for as little as 10 seconds causes a loss of consciousness; a lack of oxygen for 5 to 6 minutes causes brain cells to die (Capriotti, 2024). CVA is a cerebral vascular accident; this is a medical term for a stroke.

A stroke is a type of brain injury caused by ischemia, reduced blood flow of brain tissue or hemorrhage, and bleeding of a cerebral blood vessel; it is a clinical syndrome where a disruption in cerebral circulation causes abrupt neurological deficits that are permanent (Capriotti, 2024). An ischemic stroke is caused by a blood clot lodging in a cerebral artery and blocking blood flow to the brain tissue (Capriotti, 2024). Ischemia of brain tissue leads to cerebral infarction, the death of brain cells (Capriotti, 2024). A blood clot that causes ischemic stroke commonly arises

from one of three issues: arteriosclerosis of a cerebral artery, atrial fibrillation, which causes a cardioembolic event, or carotid stenosis, which can also cause an embolic event (Capriotti, 2024). About 80% of strokes are ischemic (U.S. National Library of Medicine, 2024).

The signs and symptoms of a CVA that my client was experiencing were severe headache, left-sided weakness, a decrease in eyesight on the left side, and loss of balance. This diagnosis was made after evaluating the patient's symptoms, the results from their CT Angio Head and Neck without Contrast, and CT Head and Brain without Contrast. Results from both CTs concluded that the patient was experiencing an acute infarct in the right parietal, occipital, and temporal regions of the brain.

Treatment for the patient will include physical therapy, rest, and preventative measures. Physical therapy is needed for the patient while they regain their strength, as they are still recovering from the last stroke that they had as well. Rest is important for the patient, as they said their head would feel better after resting. Preventing another stroke will also be very important for my patient because they have had a stroke once before, and once you have a stroke, you are at an increased risk of another.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

U.S. National Library of Medicine. (2024, April). *Stroke | CVA | cerebrovascular accident*. MedlinePlus. https://medlineplus.gov/stroke.html#:~:text=Your%20brain%20cells %20cannot%20get%20the%20oxygen,having%20a%20stroke%2C%20call %20911%20right%20away.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
BUN	21mg/dL	24mg/dL	12 – 20mg/dL	This patient has a high BUN due to them being dehydrated (Pagana et al., 2023). This lab is trending up, showing that their dehydration is getting worse, which is why they have him on continuous fluids.
Hemoglobin	17.0 g/dL	15.7 g/dL	13.0 – 16.5 g/dL	This patient had a high hemoglobin due to dehydration (Pagana et al., 2023). this lab is trending down to the normal range due to his continuous fluid.
Hematocrit	50.4%	45.0%	38.0 – 50.0%	This patient's hematocrit was high due to severe dehydration (Pagana et al.,

				2023). This lab is trending down to the normal range due to his continuous fluid.
Neutrophils	<mark>71.8%</mark>	<mark>74.4%</mark>	40.0 – 68.0%	This patients' neutrophils are high due to physical and emotional stress (Pagana et al., 2023). This lab is trending is up due to the patients physical and emotional stress of their CVA.
Lymphocytes	<mark>18.8%</mark>	<mark>16.5%</mark>	19.0 – 49.0%	This lab was low due to the patients stroke (Juli et al., 2021). This lab is trending down due to the patient's stroke causing lymphocytopenia.
Absolute Neutrophils	<mark>6.70 mcL</mark>	<mark>8.20 mcL</mark>	1.40 – 5.30 mcL	This patients' neutrophils are high due to physical and emotional stress (Pagana et al., 2023). This lab is trending is up due to

				the patients physical and emotional stress of their CVA.

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
CT Angio Head and Neck without Contrast: This test is needed because the patient is showing signs of a stroke	The patient was experiencing a worsening headache, left-sided weakness, neuro deficit, feeling "off," and their condition worsening after getting better.	There is a reduced number of blood vessels in the parietal and occipital regions, and the narrowing of the vessels is seen with plaque.
CT Head and Brain without Contrast: This test is needed because the patient is showing signs of a stroke.	The patient was experiencing a worsening headache, left-sided weakness, neuro deficit, feeling "off", and their condition worsening after getting better.	Moderate non-bleeding, tissue death is seen in the parietal, occipital, and temporal regions.

Diagnostic Test Reference (1) (APA):

Juli, C., Heryaman, H., Nazir, A., Ang, E.-T., Defi, I. R., Gamayani, U., & Atik, N. (2021, May 14). *The lymphocyte depletion in patients with acute ischemic stroke associated with poor neurologic outcome*. International journal of general medicine. https://pmc.ncbi.nlm.nih.gov/articles/PMC8131088/#:~:text=In%20patients%20with

%20acute%20ischemic%20stroke%2C%20the%20number%20of%20lymphocytes,in
%20long%2Dterm%20functional%20recovery.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's Diagnostic and Laboratory Test Reference* (16th ed.). Elsevier.

Active Orders

Active Orders	Rationale
Admission weight	Admission weight is needed to dose certain medications appropriately and monitor the patient effectively.
Insert/Maintain IV	Inserting and maintaining an IV is important while being impatient. This is also important for this patient because they are receiving continuous fluids.
Intake/Output q8h	Intake and output should be monitored and charted at least every 8 hours. This is important while the patient is receiving continuous fluids to ensure that they're not retaining fluid and that their dehydration is getting better.
Neuro checks q2h	Neuro checks should be done every 2 hours

	per protocol after a stroke. It is also important to watch for new or worsening stroke symptoms.
NIH stroke scale (admission, shift change, and any acute changes)	NIH stroke scale is routine after a stroke and should be done at admission, shift change, and with any acute changes so any changes can be noted.
Notify physician	This is a routine order in which the physician should be notified of any abnormalities.
Notify the physician medication review	The physician should be notified after medication has been reviewed with the patient so that the physician is able to order medications appropriately.
Notify physician O2 less than 94%, temperature equal to or greater than 38C	This is a routine order for after a stroke: the physician should be notified of a low O2, high temperature, or low temperature. After a stroke, the body can have trouble regulating temperature, and maintaining O2 is important.
Nursing communication if SBP is not less than 220	This order is needed after the patient has a stroke and has a history of hypertension.
Stroke education to patient and family	This is a routine order after a stroke. Education after a stroke is important to be to identify it, understand new limitations, and

	how to prevent it.
Shower with assistance	This order is important due to the patient having left-sided weakness and being at high risk of falling.
PHQ2 Depression screen admission	PHQ2 depression screening on admission is routine after a stroke and it's important to know if the patient is struggling with depression after having the stroke and be able to compare it to know whether if it's getting worse.
Obtain a modified Rankin score prior to new symptoms and discharge	This order is routine after a stroke and important to be able to determine if the patient is getting better or worse from when they came in with their stroke.
Aspiration risk tool screen	This order is routine after a stroke. After a stroke, the client is more likely to aspirate, so it's important to screen the patient first.
Sequential compression device	A sequential compression device is important after a stroke in order to lower the risk of getting a deep vein thrombosis while being unable to get out of the hospital bed.
Up as tolerated	This order allows the patient to get out of bed as soon as they are able to.

Vitals per unit	This order is routine for every patient. Vitals are important to be able to know that the patient is doing okay.

<div align="center">**Medications**</div>

Home Medications (Must List ALL)

Medications	Reason for taking
Alprazolam (Xanax) 0.25mg tablet oral twice a day as needed	The client is taking this medication due to their anxiety.
Amlodipine Besylate (Norvasc) 10mg tablet oral daily	The client takes this medication for their high blood pressure.
Aspirin 81mg chewable tablet oral daily	The client takes this medication to reduce their risk of another stroke.
Atorvastatin calcium (Lipitor) 80mg tablet oral nightly	The client is taking this medication to reduce their risk of stroke after their first stroke.
Hydrochlorothiazide 25mg oral daily	The client is taking the medication for their

	high blood pressure.
Losartan potassium (Cozaar) 100mg oral daily	The client is taking the medication for high blood pressure
Nicotine (NicoDerm CQ) 21mg/24hrs 1 transdermal patch as needed	The client uses this due to nicotine dependency.
Sertraline HCl (Zoloft) 50mg oral daily	The client takes this medication due to their anxiety.

Hospital Medications (Must List ALL)

Brand/Generic	Porcine/ Heparin 5,000 units subcutaneously every 8 hours	Vazalore/ Aspirin chewable tablets 81mg oral daily	Lipitor/ Atorvastatin 80mg oral nightly	Plavix/ Clopidogrel 75mg oral daily
Classification	Anticoagulant (Jones & Bartlett, 2024).	Salicylate anti-inflammatory,	HMG-CoA reductase inhibitor antihyperlipidemic	P2Y12 platelet inhibitor

		antiplatelet, antipyretic, nonopioid analgesic (Jones & Bartlett, 2024).	(Jones & Bartlett, 2024).	Platelet aggregation inhibitor (Jones & Bartlett, 2024).
Reason Client Taking	The client is taking this blood thinner because after having a stroke, they're at a higher risk for another one. He also benefits from taking this because he is also at higher risk for deep vein thrombosis.	The client is taking this medication to decrease their risk of having another stroke.	The client is taking this medication to reduce their cholesterol levels which overall will decrease their chance of having another stroke.	The client is taking this medication to reduce their risk of another stroke.

Key nursing assessment(s) prior to administration	The nurse should assess the patient for any signs of external or internal bleeding before administering.	The nurse should assess the patient for any signs of external or internal bleeding before administering.	The nurse should expect to see a liver panel done before starting this medication and for it to be done regularly (Jones & Bartlett, 2024).	The nurse should assess the patient for any signs of external or internal bleeding before administering. Kidney function tests and Liver function tests should also be on record because this medication is not suitable for people with renal or hepatic disease (Jones & Bartlett,

				2024).

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Atorvastatin (Lipitor)	This medication was chosen because it is used to decrease the risk of stroke.	1. This medication can cause abnormal dreams which the client states the experience before getting a "terrible headache" (Jones & Bartlett, 2024). 2. This medication can cause headaches, which my client is experiencing (Jones & Bartlett, 2024).
2. Clopidogrel (Plavix)	This medication was chosen because it's a blood thinner	1. This medication can cause headaches, which my client is

	that is being used to decrease the risk of another stroke.	experiencing (Jones & Bartlett, 2024). 2. This medication can cause nervousness which my patient has anxiety (Jones & Bartlett, 2024)
3. Heparin (Porcine)	This medication was chosen because it's a blood thinner and this is needed to decrease the risk of another stroke as well as a deep vein thrombosis from not moving out of bed.	1. This medication can cause headaches, which my client is experiencing (Jones & Bartlett, 2024). 2. This medication can cause subcutaneous deep injection-site hematoma, which the client has on their belly (Jones & Bartlett, 2024).

Medications Reference (1) (APA)

Jones & Bartlett Learning. (2024). 2024 Nurse's drug handbook (22nd ed.). Jones & Bartlett

Learning.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL:	• The patient is alert and responsive.

Alertness: **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions:** **Client Complaints or Concerns:**	• The patient is orientated to person, place, situation, and time. • The patient is showing no signs of distress. • The patient's overall appearance is appropriate to their situation. • The patient is on standard precautions and is on no isolation. • The patient is complaining about their head hurting.
VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	• Temperature was 98.4F, temporal. • Respirations are 18 • Pulse rate is 52 • Blood pressure is 104/71 • Oxygen saturation is 95% • Patient is currently on room air.
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:**	• Time of the pain assessment is 1625 • The 0-10 pain scale was utilized. • The location of the pain was in their head. • The patient states the pain is "3 out of 10". • The patient describes the pain as an ache.

Interventions:	• The intervention being utilized is rest, as the patient just wanted to take a nap to make the headache go away.
IV ASSESSMENT: **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **Fluid Type/Rate or Saline Lock:**	• The patient currently has two 20-gauge IV's • The patient has an IV in the left forearm and right antecubital. • The IV on the left was dated 2/10, and the IV on the right is dated 2/9. • Patency is intact for both IVs. They are both able to be flushed and blood drawn back. • There are no signs of erythema, drainage, or anything else from the IV sites. • Both IV sites are dry, clean, and intact. • There is a saline lock on the right IV, and there is 0.9% NaCl 100mL/ hour going into the left IV.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:**	• The patient's skin color is usual per ethnicity; they are tan color. • The patient's skin is dry. • The patient's skin is warm to the touch. • Their skin turgor is less than 3 seconds.

Rashes: **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	• The patient has no current rashes. • ==The patient has a bruise on their left lower leg, purple in color.== • ==The patient has a closed scab on their left lower leg. No signs of infection were noted.== • The patient's Braden score is 20.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	• The patient's head is symmetrical, with no lumps, bumps, or bruises noted. Their face is symmetrical and proportional, with no bruises, lumps, or lesions. The patient has full movement of their neck, no palpable lymph nodes, non-palpable thyroid, the trachea does not deviate, and no jugular vein distention noted • The patient's hearing is intact, with no lumps or bruises. The ears are symmetrical. • The patient's eyes are symmetrical and proportional to the face. No discharge is seen from the eye, the cornea is clear, the sclera is white, and the conjunctiva is

	pink. <mark>The Patient did have trouble seeing completely with their left eye</mark>. • There is no discharge from the nose. Patency is good in both nostrils. No bruises or bumps were noted on the nose. • The patient was not missing any teeth. Their mouth was pink and moist. .
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:**	• S1 and S2 were present upon auscultation. • All pulses were 2+ and present. Pulses were checked at the brachial, radial, ulnar, dorsalis, and popliteal. • Capillary refill was less than 3 seconds on all extremities, both upper and lower.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	• Clear breath sounds were auscultated bilaterally, anteriorly and posteriorly in all fields.

GASTROINTESTINAL:	• The patients diet at home is a regular diet.
Diet at home:	<mark>• The patients current diet is a cardiac diet.</mark>
Current Diet:	• The patient seems to be tolerating the diet well, no issues noted.
Is Client Tolerating Diet?	• The patient is 190.5cm.
Height:	• The patient is 105kg.
Weight:	• Bowel sounds were auscultated and present in all four quadrants.
Auscultation Bowel sounds:	• The patients last bowel movement was before admission on 02/09/24.
Last BM:	• The patient has no abdominal distention.
Palpation: Pain, Mass etc.:	• There are no incisions on the abdomen.
Inspection:	• There are no scars on the abdomen.
Distention:	• There are no drains on the abdomen.
Incisions:	• There are no open wounds on the abdomen. <mark>There are bruises from the heparin shot.</mark>
Scars:	
Drains:	
Wounds:	
Ostomy: Y ☐ N ☒	
Nasogastric: Y ☐ N ☒	
Size:	
Feeding tubes/PEG tube Y ☐ N ☒	
Type:	
GENITOURINARY:	• The patient urine color is yellow.
Color:	• Their urine is clear.

Character:
 	
Quantity of urine:
 	
Pain with urination: Y ☐   N ☒
 	
Dialysis: Y ☐   N ☒
 	
Inspection of genitals:
 	
Catheter: Y ☐   N ☒
 	
   Type:
 	
   Size:
	• The patient has peed 3 times today.
	
	• Genitals not seen, as the need was not indicated.

Intake (in mLs) **Output (in mLs)**	• The patient has received 1200mL of 0.9% NaCl over a 12-hour period. • The patient has urinated 3 times over the 12-hour shift.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:**	• The patient's nail bed is an appropriate pink color, with no signs of cyanosis bilaterally all extremities are warm to the touch and dry, with no bruises, lesions, or bumps. • The patient's range of motion is active and intact for all extremities, bilaterally. • The patient is currently no supportive devices.

Activity Tolerance: **Independent (up ad lib)** **Needs assistance with equipment** ☒ **Needs support to stand and walk**	• The patient's strength is a 5 in all extremities bilaterally. • <mark>The patient's fall score is 66.2, making them a high fall risk.</mark>
NEUROLOGICAL: **MAEW: Y** ☒ **N**☐ **PERLA: Y** ☒ **N**☐ **Strength Equal: Y** ☒ **N** ☐ **if no -** **Legs** ☐ **Arms** ☐ **Both** ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	• The patient is orientated to person, place, situation, and time. • The patient's mental status is of normal cognition. • The patient's speech is clear and easily understood. • The patient's sensory is fully intact. • The patient is currently alert. They are awake and answering questions appropriately.
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's preferred coping measures are sleeping, spending time with his wife, and smoking. • The patient's developmental level is formal operation. • The patient's religion is Christianity, and to him, it means having a higher power to give all your worries to.

	• The patient lives at home with his wife, who helps care for him.

Discharge Planning

Discharge location: The patient will be discharged home with his wife.

Home health needs: The patient does not need home health now.

Equipment needs: The patient needs a gait belt at home until they regain full mobility.

Follow-up plan: The patient should follow up with their primary care provider, outpatient therapy, and neurology within a week following discharge.

Education needs: The patient and family need education on stroke, falls, and possible new medications.

Nursing Process

Must be NANDA approved nursing diagnosis and listed in order of priority

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Nursing Diagnosis	Rationale	Outcome Goal (1 per dx)	Interventions (2 per goal)	Evaluation of interventions
• Include full nursing diagnosis with "related to" and "as	• Explain why the nursing diagnosis			

evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	was chosen			
1. Acute pain related to a build-up of pressure in the head as evidenced by the patient's constant headache (Phelps, 2023).	This nursing diagnosis was chosen because the patient came in for headache pain and continues to have pain.	Patient will rate pain on a standardized scale of 1 to 10 during this shift (Phelps, 2023).	1.Assess patient's signs and symptoms of pain behavioral cues and administer pain medication as prescribed (Phelps, 2023). 2.Use a pain scale when assessing pain (Phelps, 2023).	The patient was very responsive to the goals and interventions. The patient utilized the pain scale and was able to rate their pain appropriately.

2. Impaired walking related to impaired depth perception as evidenced by the patient's vision impairment in the left eye (Phelps, 2023).	This nursing diagnosis was chosen because of the patient's inability to walk without supervision.	The patient will maintain safety during ambulation during this shift (Phelps, 2023).	1. The patient adapts to alteration in walking (Phelps, 2023). 2.Patient maintains safety during ambulation (Phelps, 2023).	The patient was very responsive to the goals and interventions. The patient remained safe while ambulating the entire shift.
3. Anxiety related to an unfamiliar situation as evidenced by the patient asking me if I could hear a dysrhythmia of his heart	This nursing diagnosis was chosen because if the patient wasn't diagnosed, then it would still be evident that the patient has	The patient will show fewer signs of anxiety this shift (Phelps, 2023).	1. Listen attentively; allow the patient to express feelings verbally (Phelps, 2023).	The patient is hopeful of the goal and interventions but not optimistic. The patient was unable to show fewer signs of

because "a doctor asked one time if I had ever been told I have a heart dysrhythmia, but no one has ever told me I had one so I didn't know if you could hear it when you listen" (Phelps, 2023).	anxiety and is affecting their life.		2Attend to patient's comfort needs to increase trust and reduce anxiety (Phelps, 2023).	anxiety by the end of my shift.

Other References (APA):

Phelps, L.L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.