N311 Care Plan 3

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N311: Foundations of Professional Practice

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Demographics

Date of Admission 10 March 2025	**Client Initials** D.F.	**Age** 53 years old	**Biological Gender** Male
Race/Ethnicity White	**Occupation** Commercial truck driver	**Marital Status** Single	**Allergies** Iodine
Code Status Full Code	**Height** 5 ft 10 in	**Weight** 200lbs	

Medical History

Past Medical History: Client has a past medical history that consists of abdominal pain, chronic pain of neck, right arm and left hip, depression, type II diabetes mellitus, gastroesophageal reflux disease (GERD), herniated disc, sleep apnea (no use of CPAP), tobacco use disorder and Varicocele.

Past Surgical History: Client has a past surgical history that consists of, PR laminate labial veneer, PR removal gallbladder, back surgery, hand surgery, cervical fusion, carpal tunnel release, PR revise ulnar nerve at elbow, hernia repair, colonoscopy and umbilical hernia repair.

Family History: Client declined this discussion.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Client uses tobacco in the form of cigarettes and the occasional vape and claims that he is trying to quit. His history of smoking is thirty-five pack years. He also claims that he "seldomly" drinks alcohol and he declined the offer of a cessation program for both tobacco and alcohol.

Education: Client has a high school level education as well as an associates degree in Applied Science.

Living Situation: Client claims to live with a friend in a home.

Assistive devices: Client is prescribed glasses however, he does not wear them as much as he says he should.

Admission Assessment

Chief Complaint: Suspected Stroke

History of Present Illness (HPI) – OLD CARTS: The onset of the client's suspected stroke was about two weeks ago. The location of symptoms occurred in the left side and appeared as numbness/weakness. The characteristics of the suspected stroke include left sided weakness and numbness for seven days, transient ischemic attack, throbbing headache which lead to blurred vision. The duration of these signs ended about six days ago and there are no aggravating factors known. The related factors include type II diabetes mellitus, as well as smoking. His treatment plan is still in progress as further testing is needed. The tests that have been performed so far include CT of the brain with and without contrast, an MRI without contrast and a Echocardiogram. A Transesophageal Echocardiogram was scheduled to be performed however, the need for anesthesia is required for the comfort of the client. The client reported no pain throughout the day when asked.

Primary Diagnosis

Primary Diagnosis on Admission: Stroke

Secondary Diagnosis (if applicable):

Pathophysiology

Pathophysiology of the Disease, APA format: The pathophysiology of a stroke is when there is insufficient blood and oxygen supply to the brain. Inside the brain there are important carotids that control blood flow. These carotid arteries are both anteriorly and posteriorly and the

posterior is commonly referred to as the circle of Willis. The brain is a complex organ that controls the entire human body however, it can have malfunctions which may cause strokes. There are many types of strokes including ischemic and hemorrhagic. An ischemic stroke is caused when the blood flow of the brain is interrupted resulting in a lack of oxygen. It is possible for the cause of an ischemic stroke to be from a thrombosis, emboli or even atherosclerosis. Some other factors that can also contribute to an ischemic stroke include high blood pressure, atrial fibrillation, smoking, high cholesterol and diabetes. A hemorrhagic stroke results from a brain bleed when a blood vessel ruptures. Some possible causes of a hemorrhagic stroke can be from an aneurysm, arteriovenous malformation, blood disorders and head trauma. "Ischemic occlusions contribute to around 85% of casualties in stroke patients" (Kuriakose, D and Xiao, Z.), which later can create thrombotic and embolic conditions. During a thrombosis, the blood vessels in the brain slowly narrow which affects proper blood flow. Over time, plaque may build up which narrows the vascular chamber and forms a blood clot. If decreased blood flow occurs, severe stress builds up and results in death of the cells. When necrosis occurs, changes in the "plasma membrane, organelle swelling and leaking of cellular contents into extracellular space" eventually cause loss in neuronal function. It is important to know the signs and symptoms of a stroke and the acronym FAST can help identify a stroke. This acronym is used to quickly identify the most common signs of a stroke. Watch for F, face drooping, A, arm weakness, S, speech difficulty and T, time to call 911. In the client's situation he recognized his left side weakness and came to the emergency department quickly which saved his life.

Pathophysiology References (2) (APA):

Cleveland Clinic. (2024). *Hemorrhagic Stroke.* Cleveland Clinic.

Kuriakose, D and Xiao, Z. (2020). *Pathophysiology and Treatment of Stroke: Present Status and Future Perspectives.* National Library of Medicine.

American Stroke Association. (2024). *Stroke Symptoms.* American Stroke Association.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Glucose, POC	146mg/dL	163mg/dL	60-99mg/dL	These abnormal values can be related to uncontrolled type II diabetes.
White Blood Cell	13.41 10^3/uL	10.57 10^3/uL	4.0-11.0 10^3/uL	The abnormal values upon admission can be related to a type of infection or in this client's situation smoking. Smoking is strongly associated with elevated white blood cell counts because the body is responding to the harmful substances in cigarette smoke.

Red Blood Cell	4.98 10^6/uL	5.10 10^6/uL	4.10-5.70 10^6/uL	Even though this blood cell count upon admission is slightly low, it is still an abnormal level. This can be caused by an iron or vitamin deficiency, bone marrow issues, aplastic anemia or even chronic diseases.
Hemoglobin	15.1 g/dL	15.6 g/dL	12.0-18.0 g/dL	within range
Hematocrit	43.8%	45.6%	37.0-51.0%	within range
Mean Corpuscular Volume	88.0 fl	89.4 fl	80.0-100.0 fl	within range
Mean Corpuscular Hemoglobin	30.3 pg	30.6 pg	27.0-33.0 pg	within range
Mean Corpuscular Hemoglobin Concentration	34.5g/dL	34.2g/dL	32.0-36.0g/dL	within range
Red Cell Distribution Width	13.4%	13.4%	12.0-15.0%	within range

Red Cell Distribution Width Standard Deviation	43.5fl	44.1fl	36.7-46.1fl	within range
Platelet	307 10^3/uL	275 10^3/uL	140-400 10^3/uL	within range
Mean Platelet Volume	10.3 fl	10.1 fl	9.0-12.0 fl	within range

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**
CT brain without contrast: This scan uses X-rays to create cross sectional images of the head. The main focus of this scan is to view the brain, face, and skull, and the other surrounding areas. The purpose of this scan is to assess acute conditions such as brain bleeds, fractures and other structural abnormalities quickly. This test is commonly used in the emergency room setting to look for potential hemorrhage	53-year-old with 7 days of left-sided numbness.	No evidence for acute intracranial pathology.

of the brain.		
CT head and neck with contrast: The contrast that is included with this scan can be intravenous or oral contrast dye that is used to better view the blood vessels and the other structures of the image. This scan is used to find conditions such as tumors, infections, vascular problems and things such as infections.	Transient ischemic attack; headache and left-sided numbness for 7 days.	CTA Neck: WDL and no evidence of acute vascular injury. Some mild atheromatous plaque in the left more compared to the right carotid bifurcations. CTA Head: There were no proximal large vessel occlusion or important stenosis within the intracranial arteries. Cytotoxic edema versus small region of encephalomalacia in the right anterior frontal lobe. MRI is recommended. Age-indeterminates left thalamic and right

		corona radiata lacunar infarcts.
MRI head without contrast: This scan creates a detailed image of the brain and the areas around. It allows the visualization of the brain, nerves as well as the blood vessels. This test is used to detect medical problems such as a stroke, tumors and even structural problems.	Neuro deficit, acute, stroke suspected. One week ago the client woke up with a headache, left frontal throbbing achy, then during the day he had blurring of vision in his left eye followed by left-sided numbness in his left face and arm.	Acute to subacute ischemic infarction in the right frontal, parietal lobes, right posterior temporal and occipital lobe. There was no hemorrhagic transformation as well.
Echocardiogram: This non-invasive test uses an ultrasound to create detailed images of the heart. The purpose of this test is to assess the heart structure and function, diagnose heart conditions, monitor heart health, detect blood clots, assess heart rhythms, guide	Stroke/CVA	Bubble study performed. There may have been 1-2 bubbles that cross. TEE will be done for further assessment. Ejection Fraction =50-55%

surgical planning and investigate chest pain or any shortness of breath.		

Diagnostic Test Reference (1) (APA):

Assessment

Physical Exam – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

General, Psychosocial/Cultural, and TWO focused assessment specific to the client is required.

The student and instructor may complete these assessments together.

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client appears alert and oriented x person, place, and time, well groomed, no acute distress.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 17** **Drains present: Y☐ N ☐** **Type:**	The client's Braden Score is 17.
HEENT: **Head/Neck:** **Ears:**	.

Eyes: **Nose:** **Teeth:**	
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐ Edema Y ☐ N ☐** **Location of Edema:**	.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	.
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:**	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Yes** **Fall Score: 10** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐**	The client is at risk for falls and has a fall score of 10.

Needs support to stand and walk☐	
NEUROLOGICAL: **MAEW: Yes** **PERLA: Yes** **Strength Equal: YES N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status: single** **Speech:** **Sensory:** **LOC:**	Client is alert and oriented to person, place, time. Level of consciousness is based off of the Glasgow Coma Scale which is 14. Client is single and his voice is hoarse but speaks clearly. Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge noted. PERRLA and EOMS intact bilaterally. All extremities have full range of motion. Hand grips and pedal pushes and pulls demonstrate normal and equal strength. The Balance of gait is unknown from needing to stay in bed. Sensory skills are within defined limits. All pulse locations 2+ bilaterally.
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 client's developmental level has integrity and despair. He is a Christian however, he did not want to discuss what this religion meant to him and how he practices. Client claims to live with a friend and that he does feel safe in the home. He declined the discussion of family support questions. When asked, he could not describe how he feels when he needs to have a coping method. Examples were given to further help explain what a coping method is for however, he still did not give a definite answer.

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1200	**84 right radial**	**110/75 mm/Hg**	**17 breaths per min**	**97.8 F Axillary**	**97%SpO2 room air**

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
0805	**0-10**	**none**	**0**	**none**	**none**

Intake and Output

Intake (in mL)	Output (in mL)
NPO **IV: normal saline of 247.9 mL/hr (500** **total)**	**880 mL bedside urinal**

Nursing Diagnosis
Must be NANDA approved nursing diagnosis

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

1. Inadequate Health Knowledge related to inability to understand situations despite education provided, as evidenced by using statements such as “nobody tells me anything”, “I do not know what that means” and “you people do not know what you are doing to help me”.	From my experience with this client he appears agitated when the education is not provided for his standards. Being honest and using examples when discussing the plan of care allows the client to better understand the situation clearer. It is also important to establish trust and respect for a nurse-client relationship to reduce agitation and anger from the client. This nursing diagnosis will further help the client express his knowledge understanding and allow the nurse to restate or re word phrases if needed.	**1.** Walk the client through everything that you are going to do to him such as an assessment. It is important to explain the procedure before, allow for questions and then explain each move you make before touching the client to enhance the comfort of the client. This will prevent any further agitation or rage. **2.** While interacting with the client each medical personnel should explain his plan of care and any updates that are known if able. The client should feel confident in the knowledge that he understands when receiving it so	**1.** The client will show an adequate understanding of any medical information while also asking questions if needed by the end of each caregiver’s shift. Client will show reduced amounts of agitation and rage once the information is provided in an understanding that fits his educational level.	After creating a well balanced nurse-client relationship, the client responded well when receiving education about his plan of care. This education consisted of examples in multiple different ways of understanding. Speaking in a manner that the client is able to better comprehend showed an improvement of attitude as well as understanding.

		it is important to explain it in simple terms as well as using examples to prevent confusion or disbelief in your education.		
2. Risk for falls related to stroke as evidenced by previous left side weakness, headaches, vision changes.	Since the client experienced a stroke, there is evidence that he can suffer from gait issues. Since this client has remained in bed during his stay in the hospital, there is no proven reasoning whether he will be able to walk properly or not. It is important to place him at fall risk to protect and prevent him from falling and further complications.	**1.** The client should use safety precautions such as non-skid socks and a fall risk bracelet. This will help prevent falls if for some reason he were to exit his bed. The client's call light and phone should always be within reach. **2.** Items that should be needed for personal preference should be within reach at all times to prevent the need to exit the bed. Items that fit onto the bedside table should be	**1.** The client will show adequate safety precautions by wearing non-skin socks and having required items in reach. The client will also show understanding by repeating why it is important to remain in bed after a stroke by the end of shift.	After educating the client on the safety of remaining in bed, he repeated back the statements to ensure better knowledge and understanding. He now understands why he needs to use the bedside urinal as well as why the bed alarm is on continuously.

		within reach, preferably alongside the bed.		