

N431 CARE PLAN #2

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Lakeview College of Nursing

N431: Adult Health II

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03/25/2025

Demographics

Date of Admission 03/25/2025	Client Initials J. G	Age 62 years old	Biological Gender Male
Race/Ethnicity White/Caucasian	Occupation Complete Electrical Services	Marital Status Divorced	Allergies No known allergies (per patient and per chart).
Code Status Full code	Height 6'1" or 185.4 cm	Weight 127 kg or 280 pounds	

Medical History

Past Medical History: This patient has a past medical history of Hypertension, Stroke, Hypertensive urgency, Hyperlipidemia, Obesity, Chronic Kidney Disease, and Vitamin K deficiency.

Past Surgical History: This patient has a surgical history of hernia repair, and the patient stated that he did not remember the year that he had this surgery.

Family History: The patient states that "I do not have family with any medical history".

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

The patient states that "I do not use tobacco, alcohol, or drugs". The patient states that "I used to drink alcohol when I was younger, but I stopped when I was around 50." The patient stated, "I drank Friday through Sunday and had about 5 or 6 beers a night". The patient denies the use of drugs or smoking in the past.

Education: The patient states that "I graduated from high school, and I have a high school diploma, but I started working right after high school, so I did not go to college."

Living Situation: The patient lives with his mother in the Chicago area in his mother's home.

Assistive devices: The patient states that he does not use assistive devices at home, but the patient is using a walker with a gait belt during his hospital stay for a safe one assist transfers.

Admission History

Chief Complaint: The patient's chief complaint was slurred speech and left sided weakness.

History of Present Illness (HPI)– OLD CARTS

The patient presented to the emergency department in the morning of 03/25/2025 complaining of slurred speech and left sided weakness. The patient is very confused but stated that these symptoms "just happened". The patient had stated that the symptoms occurred a "few minutes" before going to the emergency department. The patient described the symptoms as numbness and tingling of the left side of this body. The location of this problem is on the left side of his face with notable left sided facial drooping. The patient denied that there was anything that made the symptoms better or worse. The student nurse asked if lying down or changing position helped and the patient denied those potential alleviating factors. The patient stated that nothing relieved the numbness or tingling of the left side of his body. The provider, in the emergency department, ordered a CT of the head and neck, CT of the head, MRI, and chest x-ray to evaluate these symptoms. He was then given Labetalol IV to help relieve elevated blood pressure. The emergency room nurse gave the patient Aspirin orally and Heparin subcutaneously in the abdomen for prevention of thrombus.

Admission Diagnosis

Primary Diagnosis: Ischemic Stroke

Secondary Diagnosis (if applicable): Hypertensive urgency, Hyperlipidemia, Obesity, Chronic Kidney Disease, Vitamin K deficiency.

Pathophysiology

The patient came into the emergency department with complaints of slurred speech and left sided weakness, and this was new to him. After multiple tests, including the MRI, CT scans, and chest x-ray. It was determined that this patient had an ischemic stroke and was then admitted to the 4th floor medical surgical unit.

An Ischemic stroke is defined as a disruption in blood flow to the brain due to an obstruction of a blood vessel (Hinkle et al., 2022, p. 2033). The two vessels that are prominently involved in an ischemic stroke are the internal carotid and middle cerebral arteries (Capriotti, 2020, p. 806). There is a complex scale of metabolic events that is called an ischemic cascade (Hinkle et al., 2022, p. 2033). This cascade starts with blood flow decreasing and the neurons in the brain are not able to maintain aerobic respiration (Hinkle et al., 2022, p. 2033). Then, the mitochondria must switch to anaerobic respiration which makes large amounts of lactic acid, which then causes a change in the pH (Hinkle et al., 2022, p. 2033). The switch to the less effective anaerobic respiration makes the neuron unable to produce quantities of ATP to fuel the depolarization processes (Hinkle et al., 2022, p. 2033). Then the final step of the cascade is when the membranes that maintain electrolyte balances begin to fail and the cells begin to stop working (Hinkle et al., 2022, p. 2033). An ischemic stroke has decreased tissue perfusion to all other organs to the body. This will cause organ damage and if not treated promptly, due to the lack of oxygen and blood flow due to the blockage of the blood vessels to the brain (Hinkle et al., 2022, p. 2033). The patient's symptoms have caused damage to the brain and also nerve damage, and this is evidenced by the patient's unsteady gait.

There are many signs and symptoms of an ischemic stroke which include slurred speech, paralysis of the face and extremities. They are usually on the same side as this patient who experienced left sided weakness, unsteady gait, confusion, irritation, and difficulty forming words with left facial droop (Hinkle et al., 2022, p. 2034). These were very prominent in the initial assessment.

The primary diagnosis of this patient was determined in the emergency department when the patient came in with slurred speech and left sided weakness. The providers ran many tests including a CT, chest x-ray, and an MRI to determine what was going on with this patient. The provider wanted to have multiple tests done before diagnosing this patient.

The patient treated this client with Labetol IV, oral Aspirin, and subcutaneous Heparin to help reduce the risk for bleeding and to manage the patient's severely high blood pressure. Aspirin and Heparin were used to prevent blood clot formation due to the patient's elevated hemoglobin, hematocrit, INR, and PT lab values. The Labetalol that was given intravenously, is an antihypertensive (Jones & Bartlett, 2023, p. 739). This medication blocks alpha and beta receptors in smooth muscle and beta receptors in the heart to reduce blood pressure... (Jones & Bartlett, 2023, p. 739).

Clinical data that helped diagnosis the patient's diagnosis is the patient's hematocrit and hemoglobin levels, a CT of the head and neck, a CT of the head without contrast, a chest x-ray, and an MRI. The CT of the head and neck showed ischemia within the tissue of the brain. The CT of the head, in contrast, was unable to be used due to this type of imaging being unable to detect a recent infarct of the brain. The chest x-ray did not show

any acute findings. The MRI was not finished before the nursing student left the floor. At the time 1832, the results were still not finalized.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company: ISBN 9780803694118

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

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Creatinine Blood	1.46	N/A	0.70-1.30 mg/dL	The patient has a new diagnosis of chronic kidney disease which can cause this level to be elevated (Pagana et al., 2023, p. 296-297).
GFR	54	N/A	>=60	The patient has a new diagnosis of chronic kidney disease which can

				cause the GFR to be decreased (Pagana et al., 2023, p. 299).
Glucose	181	N/A	70-99 mg/dL	The reason why this lab can be elevated is due to the patient having a stroke, which is a stressful episode, and this can cause blood glucose levels to rise (Pagana et al., 2023, p. 453).
INR	1.2	N/A	0.8-1.1	This patient has a past medical history of Vitamin K deficiency, so this causes the INR to be elevated (Jones & Bartlett, 2023, p. 736).
Pro time - Patient	13.8	N/A	10.1-13.1 seconds	This patient has a history of Vitamin K deficiency, and this can cause PT lab values to be elevated (Jones &

				Bartlett, 2023, p. 736).
RBC	6.49	N/A	4.40- 5.80 10(6)/mcL	That patient has not had fluids in over 12 hours, so this patient is dehydrated. Dehydration can cause the patient's red blood cell value to be elevated (Pagana et al., 2023, p. 750).
Hemoglobin	18.6	N/A	13-16.5 g/dL	The patient is taking a salicylate, Aspirin, which can cause this level to increase (Pagana et al., 2023, p. 913).
Hematocrit	55.4	N/A	38-50 %	The patient's hemoglobin and red blood cell count are both elevated. Hematocrit closely reflects the red blood cell count and hemoglobin which can cause the hematocrit

				<p>level to increase (Pagana et al., 2023, p. 476). This abnormal value has the same pathologic reason as red blood cells and hemoglobin (Pagana et al., 2023, p. 476). The patient is dehydrated so this can be an indication of why this lab value is increased as well (Pagana et al., 2023, p. 476).</p>
Neutrophils	85.4	N/A	40-68%	<p>The patient has had a significant amount of physical and emotional stress related to uncontrolled hypertension and ischemic stroke (Pagana et al., 2023, p. 947). This is an indication of why this lab value could be</p>

				elevated in this patient.
Lymphocytes	7.2	N/A	19-49%	This patient has bacteria in the urine which can be an indication of an infection. There is not a diagnosis of an infection nor an abnormal white blood cell count, but lymphocytes help fight infection and there is an alteration in this value (Pagana et al., 2023, p. 947). This could be something that the student nurse would communicate to the doctor.
Protein, random urine	3+	N/A	Negative	The patient has had severe stress which can cause hemoglobin to decrease, and the patient is taking a salicylate, Aspirin, which can cause

				this level to increase (Pagana et al., 2023, p. 913).
Urine glucose	2+	N/A	Negative	This urine lab is concerning due to the patient not having Diabetes mellitus; however, the patient does not maintain his overall health. This can be an undiagnosed issue that needs to be addressed by the provider.
Urine blood	Trace	N/A	Negative	The patient has chronic kidney disease, and this medical condition can cause blood to spill into the urine (Pagana et al., 2023, p. 917).
Bacteria, urine	Few	N/A	Negative	This patient could have an underlying infection that has not been treated

				(Pagana et al., 2023, p. 919). This is possible due to the patient being noncompliant with his health.
Hyaline Casts	Occasional hyaline casts	N/A	Negative	This lab can be shown in the patient's urine if the patient has chronic kidney disease (Pagana et al., 2023, p. 915).

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
CT of head and neck related to suspected diagnosis of stroke with contrast.	Left sided weakness, irritability, confusion, speech slurring.	Ischemia
CT Stroke of Head without contrast	The patient had symptoms of irritability, confusion, slurred speech, and visual facial drooping.	Unable to determine due to this type of imaging that cannot detect a recent infarct so patient will be sent to MRI for further testing.
Chest Xray	The patient had symptoms of	No acute findings

	slurred speech and left sided weakness.	were found within the chest x-ray.
MRI of the brain without contrast	The patient had symptoms of slurred speech and left sided weakness which led to this diagnostic test being conducted.	Results have not been finalized and are waiting for results as of 1832.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's diagnostic and laboratory test reference* (16th ed.). Mosby.

Active Orders

Active Orders	Rationale
CPR full code	While the patient is under the care of OSF, the hospital will perform life saving measures if the patient codes during the hospital stay per patient. Request signed by the doctor.
General Diet	This patient is on a general diet due to speech therapy evaluating the patient and deeming it safe for the patient to have this diet after the stroke.

Consult to Neurology	This patient has had a stroke so follow up care with a Neurologist is crucial for positive patient outcomes. The Neurologist can help promote a plan for the patient to recover from this event.
OT/PT Evaluation	This is related to stroke diagnosis and building strength, so he can live at home again. This will be helpful to help the patient gait and balance, so the patient is able to perform ADLs on his own.
Admission weight	Baseline weight needed.
Ambulate patient 3 times daily	Patient can ambulate with one assist to help maintain adequate ROM.
Cardiac monitoring	The patient has had a stroke and has a critically high blood pressure so cardiac monitoring is put in place to monitor the patient's cardiac function. This will be monitored due to risk for dysrhythmias.
Neuro checks every 4 hours	The patient had a recent stroke so the nurse will assess the patient's neurologic status every 4 hours to determine if there are signs of further complications or improvement.

Maintain peripheral IV	This is for IV medications and for the use of contrast during his CT scan that he had performed prior to coming to the 4 th floor medical surgical unit.
Perform INR and PT	The patient's INR and PT are elevated, so the provider ordered these lab values to be drawn to determine if the medications have made the client's values become within the therapeutic range. The therapeutic ranges for these lab values are as follows: INR: 0.8-1.1 PT: 10.1 – 13.1 seconds
Speech Evaluation	The patient has had a stroke, so the speech evaluation is for safety of food and fluids and to avoid choking and aspirating.

Medications

Home Medications (Must List ALL) Patient denied taking any medications at home per patient and chart.

Medication	Reason for taking
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Hospital Medications (Must List ALL)

Brand/ Generic	Aspirin (rectal or oral)	Atorvastatin	Acetaminophen (Tylenol)	Heparin (Porcine)	Hydralazine (Apresoline)
Classification	Pharmacologic: Salicylate Therapeutic class: NSAID, antiplatelet, antipyretic, nonopioid analgesic (Jones & Bartlett Learning, 2023)	Pharmacologic: HMG-CoA reductase inhibitor Therapeutic: Antihyperlipidemic (Jones & Bartlett Learning, 2023 p. 116).	Pharmacologic: Non salicylate, para- aminophenol derivative Therapeutic: Antipyretic , nonopioid analgesic (Jones & Bartlett Learning, 2023)	Pharmacologic: Anticoagulant Therapeutic: Anticoagulant (Jones & Bartlett Learning, 2023, p. 646).	Pharmacologic: Vasodilator Therapeutic: Antihypertensive (Jones & Bartlett Learning, 2023, p. 650).
Reason Client Taking	Prevention of blood clots	Hyperlipidemia	Pain management	DVT prevention	For heart rate and blood pressure

					systolic greater than 220.
List two teaching needs for the medication pertinent to the client	Educate the client to not take naproxen or ibuprofen while taking this medication because these medications can reduce the stroke preventative effects of aspirin (Jones & Bartlett Learning, 2023) Educate the patient on	Educate the client to take the drug at the same time every day to maintain optimal effects (Jones & Bartlett Learning, 2023, p. 119). Educate the client that this medication is an addition and not a substitute for a low cholesterol diet (Jones &	Educate the patient on not taking other medication s containing acetaminop hen at the same time because of the risk of liver damage (Jones & Bartlett Learning, 2023, p. 12). Instruct the patient to	Advise the patient to avoid using drugs like Aspirin because these drugs can interact with each other (Jones & Bartlett Learning, 2023, p. 650). Educate the client about the increased risk for bleeding	Educate the patient to not stop taking this medication abruptly because this can cause severe hypertension (Jones & Bartlett Learning, 2023, p. 652). Educate the patient on reporting symptoms of numbness and tingling in the

	taking this medication with food of after meals to avoid GI upset (Jones & Bartlett Learning, 2023).	Bartlett Learning, 2023, p. 119).	read the manufacturer's label and follow the dosage guidelines and to not exceed the maximum daily amount (Jones & Bartlett Learning, 2023, p. 12).	and to avoid activities that could cause injury (Jones & Bartlett Learning, 2023, p. 650).	extremities, this may need to be treated with another drug prescribed by the doctor (Jones & Bartlett Learning, 2023, p. 652).
Key nursing assessment (s) prior to administration	Monitor the patient's INR and PT closely while this patient is taking this medication to determine if	Monitor the patient's liver function lab results before giving this medication due to this medication	Before administering this medication, perform a pain assessment on the client using a pain scale that is appropriate for the client's age and	Monitor for dyspnea or wheezing after the administration of this medication	Monitor the patient's pulse and blood pressure before administration (Jones &

	<p>the patient's lab values are within therapeutic range (Jones & Bartlett Learning, 2023).</p>	<p>being able to impair liver function (Jones & Bartlett Learning, 2023, p. 119).</p>	<p>developmental level. This patient can use the numeric scale when conducting a pain assessment.</p>	<p>(Jones & Bartlett Learning, 2023, p. 649). Assess this patient due to the patient having severe uncontrolled hypertension, which can increase the risk of hemorrhage (Jones & Bartlett Learning, 2023</p>	<p>Bartlett Learning, 2023, p. 651).</p>
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				, p. 649). This seems like these two medications interact, however they work in different ways to thin the blood. These two together are therapeutic.	
Brand/ Generic	Labetalol (Normodyne)	Scopolamine (TRANSDERM-SCOP)	Polyethylene glycol (MiraLAX)	Zofran (Ondansetron)	
Classification	Pharmacologic: Noncardioselective beta-blocker/ alpha 1 blocker Therapeutic: Antihypertensive (Jones & Bartlett Learning, 2023, p. 739).	Pharmacologic: Belladonna alkaloid Therapeutic: Antiemetic (Jones & Bartlett Learning, 2023, p. 1220).	Pharmacologic and therapeutic class: laxatives (Sinha, 2024).	Pharmacologic: selective serotonin receptor antagonist Therapeutic: antiemetic (Jones & Bartlett Learning, 2023).	
Reason Client	Blood pressure	Nausea/vomiting	Constipation	Nausea/vomiting	

Taking	greater than 220 systolic			
List two teaching needs for the medication pertinent to the client	<p>Educate the patient on not stopping the medication abruptly because this can cause rebound hypertension (Jones & Bartlett Learning, 2023, p. 740).</p> <p>Advise the patient to monitor for signs of bradycardia and report them to their primary care</p>	<p>Instruct the patient to put the patch behind the ear in a hairless area (Jones & Bartlett Learning, 2023, p. 1220).</p> <p>Instruct the patient to take the patch off before going to MRI because this can cause burns on the skin, and this patient went to MRI (Jones & Bartlett Learning,</p>	<p>This medication should be taken with a substantial amount of water (Sinha, 2024).</p> <p>This medication should produce a bowel movement within a day of administering (Sinha, 2024).</p>	<p>Let the tablet dissolve under the tongue (Jones & Bartlett Learning, 2023, p. 1015).</p> <p>Use the given oral suspension provided with the prescription Jones & Bartlett Learning, 2023, p. 1015).</p>

	provider (Jones & Bartlett Learning, 2023, p. 740).	2023, p. 1221).		
Key nursing assessment (s) prior to administration	Monitor pulse and blood pressure before administering this medication because this can cause hypotension (Jones & Bartlett Learning, 2023, p. 740).	Monitor for pain before putting a new patch on (Jones & Bartlett Learning, 2023, p. 1221). Monitor heart rate before administering (Jones & Bartlett Learning, 2023, p. 1221).	Monitor the patient's electrolyte levels before administering this medication if this medication is being used for long term purposes.	Monitor for tachycardia and arrhythmias (Jones & Bartlett Learning, 2023, p. 1015).

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your
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		client
1. Labetalol	This medication was chosen due to the patient having a critically elevated blood pressure of 187/114 and maintaining critically high blood pressures.	1. Ventricular Arrhythmias Jones & Bartlett Learning, 2023, p. 740). 2. Hypotension Jones & Bartlett Learning, 2023, p. 740).
2. Aspirin	The patient has had an ischemic stroke which is causing impaired blood flow. The patient's hemoglobin and hematocrit are elevated, which puts the patient at risk for a DVT as well (Jones & Bartlett Learning, 2023, p. 106).	1. Thrombocytopenia Jones & Bartlett Learning, 2023, p. 107). GI bleeding Jones & Bartlett Learning, 2023, p. 107).
3. Heparin	The patient has had a stroke and is at risk for developing a blood clot, and this medication is a sufficient medication for DVT prevention (Jones & Bartlett Learning, 2023, p.	1. Hemorrhage Jones & Bartlett Learning, 2023, p. 649). 2. Thrombus (Jones & Bartlett Learning, 2023, p. 649).

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Medications Reference (1) (APA)

Jones & Bartlett Learning. (2023). 2021 *Nurse's drug handbook* (22nd ed.). Jones & Bartlett Learning.

Sinha, Sanjai. (2024 March 22). *Mira LAX*. <https://www.drugs.com/miralax.html#before-taking>

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance: Infection Control precautions: Client Complaints or Concerns:</p>	<p>The patient is alert and orientated to self and situation but is confused to place and time. The patient denies that he is not in distress currently and denies pain currently. The patient body shows evidence of poor grooming and lack of personal hygiene. Body odor was noted upon assessment. Nails and hair are unkempt. The patient does not have any infection control precautions in place. The patient does not have any complaints or concerns currently. The provider has a concern about the patient's blood pressure due to it being 187/114, however when discussing this concern with the client, the patient was not concerned, and he was confused.</p>
<p>VITAL SIGNS: Temp: Resp rate: Pulse: B/P: Oxygen: Delivery Method:</p>	<p>Vital signs were taken at 1632. Temperature: 98.3 degrees F Respiratory rate: 20 Pulse: 68 beats per minute Blood Pressure: 187/114 Oxygen saturation: 94% Delivery Method: room air</p>
<p>PAIN ASSESSMENT: Time: Scale: Location: Severity: Characteristics: Interventions:</p>	<p>Pain assessment was at 1632. The patient rates his pain a 0/10 on the numeric scale. The patient does not have any pain currently so there is not a site of pain on the patient's body. The patient does not describe pain to the student nurse due to him not having any pain currently. The patient is sitting in bed with clean sheets and has</p>

	recently been to the bathroom. The patient is resting comfortably.
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:	<p>The patient has two IV sites. One of them is in the left posterior forearm and the second IV site is in the right antecubital. IV sites are 20-gauge catheters. Both IV sites are patent when flushed with no signs of erythema, drainage, or pain. Both IV site dressings are clean, dry, and intact. These IVs were placed this morning at 0049 this morning. IV sites are saline locked.</p>
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	<p>The patient's skin color is normal for patient's race and ethnicity. The patient's skin is tough and dry. The patient's skin temperature is cool to touch in the lower extremities and warmer in the upper trunk of the body. Skin turgor is less than 3 seconds. The patient does not have any rashes or wounds. The patient has bruises on bilateral knees and bilateral arms. The patient has a few bruises as well on the lower stomach from the heparin injections. The patient's Braden score is 13. The patient does not have any drains present upon assessment.</p>
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	<p>The patient's head and neck are midline to the body. Ears do not have signs of redness, drainage, or wounds. The patient's left eye is drooping lower than the right eye due to the patient having a recent stroke. The patient's nose has been shifted to the left side due to the stroke. The patient is missing several teeth, and they are unkempt upon assessment.</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>S1 and S2 noted. Peripheral pulses are all 2+ which includes radial, brachial, popliteal, dorsalis pedis, and dorsalis tibialis. Capillary refill is 4 seconds in bilateral lower extremities and less than 3 seconds on bilateral arms. The patient did not have jugular vein distention noted upon assessment. The patient has slight +1 edema on bilateral lower extremities.</p>
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	<p>The patient is not using any accessory muscle use currently upon assessment. Breath sounds were clear in all four lobes bilaterally.</p>

<p>GASTROINTESTINAL: Diet at home: Current Diet: Is Client Tolerating Diet? Height: Weight: Auscultation Bowel sounds: Last BM: 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 has a normal diet at home. This patient was NPO until speech therapy came and assessed the patient after the stroke at 1420. After the speech therapist finished the assessment, the patient was clear to have a general diet while in the hospital with the help of feeding. The client is tolerating the diet. The patient's height is 6'1" and his weight is 280 pounds. Bowel sounds were hypoactive in all four quadrants, but the patient has been NPO since 0049 this morning. The student nurse helped the patient order dinner after completing the assessment. Upon palpation, the patient did not have any pain, masses, or organomegaly. The patient's stomach was slightly distended but did not have any incisions, scars, drains, or wounds upon inspection. The patient did have a few bruises on the lower stomach due to the Heparin injections that nurse was giving him. The patient did not have an ostomy, a nasogastric tube, or a feeding tube.</p>
<p>GENITOURINARY: Color: 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:</p>	<p>The patient's urine was a little cloudy upon inspection and dark yellow. The patient urinated 700 in the urinal. The patient did not complain of any pain with urination. The patient does not have dialysis. The patient's genitals were normal for patients of age and race. There were not any lesions or scars inspected of the genitalia. The patient does not have a catheter.</p>
<p>Intake (in mLs)</p> <p>Output (in mLs)</p>	<p>Intake: 480 mL.</p> <p>Output: 700 mL's in urinal.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p>	<p>The patient has numbness on the left side of his body with weakness and facial drooping noted. The patient can move the right side of his body well but had trouble using the left side of his upper and lower extremities. The patient has a</p>

<p>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score: 49</p> <p>Activity/Mobility Status: Activity Tolerance: Independent (up ad lib) Needs assistance with equipment Needs support to stand and walk</p>	<p>walker and gait belt at bedside to help with transfers to and from the bathroom. The patient's strength on the left side of his body was very weak and had slower movements when performing activities but the right side of the patient's body is within normal limits of the patient's age. The patient is a fall risk, and his score is 49. The patient is a one-assist transfer with walker and gait belt and needs assistance with ADL's.</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input checked="" 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 does not move all 4 extremities well. The patient has left sided weakness, so it is very difficult to move the left upper and lower extremities. PERLA was not intact. Pupils are round and equal but upon assessment, they are not reactive to light. This is due to the patient's stroke. The patient's strength is not equal on bilateral upper and lower extremities due to the patient having left sided weakness. The patient's left upper and lower extremities have a significant weakness compared to the right arm and leg. The patient is oriented to self and situation but is confused to setting. The patient's mental status was altered and it took long periods of time to speak to the nurse and student nurse. The patient had sensation in his right side but stated that he could not feel the left side of his body. Patient is lethargic but will speak to nurse and student nurse when prompted to do so.</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 patient likes to watch television and take naps. The patient states that he works a lot and does not have motivation to do anything after work. The patient's developmental level is appropriate for the client's age. The patient did not express that he practiced a certain religion, but the patient stated that he "Believed in God". The patient lives at home with his mother in Batavia which is a suburb in Chicago, IL. The patient stated that he was visiting a friend in Danville when he had the stroke.</p>

Discharge Planning

Discharge location: There is a consultation for this patient to go to OSF Heart of Mary in Urbana to do inpatient physical, occupational therapy, and speech therapy. After the stay in Urbana, the patient wants to return home.

Home health needs: This patient will be receiving physical therapy in Urbana so we will want to follow up with safety measures in the house including grab rails and taking out any movable rugs. Possibly adding rails or a walk-in tub to reduce falls in the shower.

Equipment needs: The patient will need a walker at home to help maintain adequate balance when ambulating at home by himself.

Follow up plan: After discharge, the patient has a consultation to go to inpatient rehab at Heart of Mary in Urbana. The plan after rehab is to go home to live in his house with his mother.

Education needs: The client needs education on taking blood pressure at home, medication regimens, teaching of signs and symptoms of stroke, and maintaining personal hygiene.

Nursing Process

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

Nursing Diagnosis <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 priority 	Rationale <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Outcome Goal (1 per dx)	Interventions (2 per goal)	Evaluation of interventions

pertinent to this client				
1. Ineffective Cerebral tissue perfusion related to neurologic dysfunction as evidenced by ischemic stroke (Phelps, 2020,	This nursing diagnosis was chosen due to the patient having a blockage in the brain noted by the CT of the head and neck showing ischemia. This ischemia will cause ineffective cerebral perfusion due to the death of the tissue in the brain.	The patient will understand factors that can help improve circulation by the end of the hospital stay.	1. Monitor the patient for risk factors of further decrease in cerebral perfusion, including hypertension and coagulopathies (Phelps, 2020, p. 710). 2. Maintain adequate oxygenation (Phelps, 2020, p. 710).	The physical therapist spoke to the patient about exercises that they will implement in his plan of care to promote mobility and blood circulation.
2. Self-care deficit as evidenced by physical assessment findings and left sided weakness related to ischemic stroke (Phelps, 2020, p. 576).	This nursing diagnosis was chosen because of the student nurse's assessment of the patient's overall hygiene. The patient will need to have more assistance with personal hygiene due to the paralysis on the left side of the patient's body. Overall poor hygiene can be detrimental to the patient's health.	The patient will do most of his personal hygiene (within limits) before he is admitted to Heart of Mary for his rehabilitation stay.	1. Allow the patient to have adequate time to complete ADL's and help when needed (Phelps, 2020, p. 576). 2 Provide the patient with hygiene products to complete daily hygiene practices. Monitor for bathing compliance daily (Phelps, 2020, p. 576).	The nursing student assessed the patient, and he was able to clean his genitalia after using the urinal without assistance from staff.
3. Risk for	This nursing	The patient	1. Educating	The patient

<p>falls related to unsteady gait as evidenced by observation of physical therapy consultation (Phelps, 2020, p. 227).</p>	<p>diagnosis was chosen due to the patient's musculoskeletal and neurological status. The patient has had a recent stroke, which caused the patient to have severe muscle weakness. This indicates a risk for falls.</p>	<p>will be able to lift a 5-pound weight with the left arm before he discharges to Heart of Mary Rehabilitation .</p>	<p>the client on using an assistive device when ambulating. Also educating the patient on proper etiquette of using the device (Phelps, 2020, p. 228).</p> <p>2. Educating client on household safety when he discharges to home from Heart of Mary (Phelps, 2020, p. 228).</p>	<p>will demonstrate the proper way of using a walker during his hospital stay at Heart of Mary. This student nurse believes that the patient will be able to demonstrate this task in 1-2 weeks.</p>
<p>4. Impaired swallowing related to facial numbness and left sided facial drooping as evidenced by ischemic stroke diagnosis (Phelps, 2020, p. 681).</p>	<p>This nursing diagnosis was chosen because of the student nurse's observation of the patient eating. The student nurse observed difficulty chewing food completely and difficulty swallowing was observed.</p>	<p>The patient will be able to chew and swallow adequately before the end of his hospital stay.</p>	<p>1. Consult with a dysphagia rehabilitation team for expert advice (Phelps, 2020, p. 683).</p> <p>2. Apply pressure above the lip to stimulate mouth closure and the swallowing reflex (Phelps, 2020, p. 684).</p>	<p>The nurse will evaluate the patient during meals to assess for dysphagia and document appropriately .</p>

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Other References (APA):

Phelps, L.L. (2023). *Nursing Diagnosis Reference manual*. (12th ed.). Wolters Kluwer.

