N321 CARE PLAN #1

Hazelyn Hunter

Lakeview College of Nursing

N321: Adult Health I

Professor Kristal Henry

September 12, 2025

Demographics

Date of Admission	Client Initials	Age	Biological Gender
9/6/25	S.T.	86 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Retired from working at State Farm	Widowed	No known
Code Status	**Height**	**Weight**	
No CPR - Selective Treatment	5ft 1in	140lbs	

Medical History

Past Medical History: The client discussed her past medical history verbally. She stated that she had measles at three years old and two natural births later in life. She has a history of anxiety, hypertension, hyperlipidemia and four previous cerebrovascular accidents/Transient Ischemic attacks. The client discussed her pessary device is used to support and hold her bladder in place. She has had this device for three to four years and has been getting it replaced monthly.

Past Surgical History: The client states that she had a benign sublingual mass removed about three to four years ago.

Family History: The client states that cardiac problems are associated with both maternal and paternal sides. She has a history of maternal hemorrhagic stroke and cancer paternally.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The client has never used tobacco, alcohol or drugs.

Education: The client's highest education level is her high school diploma.

Living Situation: The client lives at home alone and her daughter visits every other day to check in.

Assistive devices: The client uses a quad cane, walker, reading glasses and an upper partial denture.

Admission History

Chief Complaint: Suspected stroke

History of Present Illness (HPI)– OLD CARTS: The client began experiencing stroke symptoms at 0300 on Saturday which disrupted her sleep. She described her symptoms to be occurring in her head which lasted about three to four hours long. The characteristics of her stroke include generalized weakness, fatigue, dull temporal headache which radiated behind her neck, blurred vision, numb lips and she felt like she was "out of it". She stated that there were no aggravating or reliving factors and that "it was a the same no matter what" while experiencing her stroke. The treatment for her suspected stroke included thrombolytic therapy. The client stated that she was not in any pain throughout this suspected stroke and rated a 0 out of 10 on a numeric pain level.

Admission Diagnosis

Primary Diagnosis: Cerebrovascular accidents/Transient Ischemic attack

Secondary Diagnosis (if applicable): None

Pathophysiology

A cerebrovascular accident occurs when a disruption of cerebral circulation occurs which may result in an ischemic or hemorrhagic stroke. However, another type of ischemic injury is a transient ischemic attack (TIA) which may also be called a "mini stroke". A transient ischemic attack occurs when an embolus is abruptly dislodged into an arteriosclerotic arterial vessel which results in the occlusion of blood flow in the brain (Capriotti, 2024). It is common for the clinical presentations of a TIA to be similar to a stroke. The difference between a stroke and a TIA occurs within 24 hours of the clinical presentations. Some common clinical

presentations of a TIA include headache, vision changes, facial drooping, deconjugate gaze, abnormal tongue movement and weakness in the face, tongue, upper or lower extremities (Panuganti et al., 2023). During a TIA, the fibrinolytic system in the body essentially dissolves the embolus that is causing the occlusion of blood flow, and any deficits typically disappear within 24 hours (Capriotti, 2024). During this occurrence, there are no permanent neurological injuries that occur however, a TIA is often described as a warning sign for future strokes (Capriotti, 2024). It is important to have diagnostic testing completed within 24 hours to confirm a TIA such as a head CT, CTA, MRI, ECG, carotid ultrasonography, or an arteriography to find any blockages or origin (Panuganti et al., 2023). Clients who are admitted with suspicion of a TIA should have routine blood tests drawn including a "CBC, PT/INR, CMP, FBS, lipid panel, urine drug screen and ESR" (Panuganti et al., 2023). Treatment of a TIA should include beginning an antiplatelet therapy such as aspirin to prevent future clots, anticoagulation therapy, lifestyle modifications and in serious cases, surgery (Panuganti et al., 2023). In regard to the client, she had clinical presentations of weakness, a dull temporal headache, blurred vision, numb lips and fatigue. The client stated that she was "out of it all morning and thought she was just hungry". Her diagnostic imaging includes a CTA Stroke Head and Neck as well as a CT Stroke Head without contrast. The client had an order from her provider for many labs drawn related to the TIA. The treatment plan for the client includes antiplatelet therapy and anticoagulation therapy.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Pathophysiology, Introductory Concepts and Clinical Perspectives. (3rd Edition).* Davis Advantage.

Panuganti, K., Tadi, P. & Lui, F. (2023). *Transient Ischemic Attack.* National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK459143/.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Protein, Random Urine	Trace!	N/A	Negative	The urine test shows that there is a small trace of protein found in the urine which is trending up. This trace may be related to hypertension, and potential urinary tract infection (Pagana et al., 2021).
Specific Gravity	>1.030	N/A	1.003-1.030	The urine test shows that the specific gravity is trending up which is concentrated urine and may be related to dehydration (Pagana et al., 2021).
Urine blood	1+! ery/ul	N/A	Negative ery/ul	The urine test shows that there is a small amount of

				blood detected which is trending up. The potential reasoning for this lab could be related to the low dose of aspirin (Pagana et al., 2021).
WBC Esterase	2+!	N/A	Negative	This urine test is trending up which indicates a urinary tract infection when positive (Pagana et al., 2021).
Bacteria, urine	Packed! /hpf	N/A	Negative/hpf	The urine test shows packed bacteria which is trending up and indicates a urinary tract infection (Pagana et al., 2021).
WBC urine	11-20! /hpf	N/A	Negative, 0-5/hpf	The urine test shows WBC levels trending up which indicates a urinary tract infection (Pagana et al., 2021).
Urine Ketones	2+!	N/A	Negative	The urine test shows urine ketone levels

				trending up which may be related to the clients insufficient diet (Pagana et al., 2021).
Sodium	130 mmol/L	135 mmol/L	136-145 mmol/L	The sodium level is trending down which may be related to the urinary tract infection and peripheral edema (Pagana et al., 2021).
Glucose	116 mg/dL	98 mg/dL	70-99 mg/dL	The glucose level is trending up which may be related to the urinary tract infection (Pagana et al., 2021).
Calcium	8.4 mg/dL	8.4 mg/dL	8.7-10.5 mg/dL	The calcium level is trending down which may be related to her aspirin medication (Pagana et al., 2021).
Total Protein	5.7 g/dL	5.5 g/dL	6.0-8.0 g/dL	The total protein level is trending down which may be related to the

				urinary tract infection and insufficient nutrition (Pagana et al., 2021).
MPV	7.4 fL	8.0 fL	9.7-12.4 fL	The MPV levels are trending down which may be related to the urinary tract infection or bone marrow changes related to the natural aging process (Pagana et al., 2021).
Neutrophils	84.0%	65.2%	47.0-73.0%	The neutrophil level is trending up which may be related to bacteria from the urinary tract infection and may also be related to the stroke (Pagana et al., 2021).
Lymphocytes	8.8%	19.5%	18.0-42.0%	The lymphocytes levels are trending down which may be related to bacteria from the urinary tract infection and may also be

				related to the stroke (Pagana et al., 2021).
Absolute Lymphocytes	0.70 10^3/mcL	1.40 10^3/mcL	1.30-3.20 10^3/mcL	The absolute lymphocyte level is trending down because of the urinary tract infection and related to immobility (Pagana et al., 2021).
RBC	3.87 10^6/mcL	3.73 10^6/mcL	3.80-5.30 10^6/mcL	The RBC level is trending down which may be related to dietary deficiency (Pagana et al., 2021).
Hemoglobin	12.6 g/dL	11.9 g/dL	12.0-15.8 g/dL	The hemoglobin level is trending slightly down and may be related to the urinary tract infection (Pagana et al., 2021).
Hematocrit	36.2%	35.2%	36.0-47.0%	The hematocrit levels are trending down which may be related to dietary deficiency (Pagana et al., 2021).

Previous diagnostic prior to admission (ER, clinic etc.) if pertinent to admission diagnosis	Previous diagnostic results and correlation to client admission	Current Diagnostic Test & Purpose	Clients Signs and Symptoms	Results and correlate to client diagnosis and condition
N/A	N/A	CTA Stroke Head & Neck: This diagnostic provides a visual image of the blood vessels in the head and neck to detect the cause of the TIA (Pagana et al., 2021). Some examples of causes may include a narrow or blocked artery which may lead to another possible TIA (Capriotti, 2024).	The client experienced slurred speech, headaches, blurred vision, numb lips and weaknesses.	The results showed that there were no intracranial changes or abnormalities. Nonspecific white matter changes and volume loss and no stenosis or occlusion of the blood vessels. These results show that there are no

				indications of blockage or stroke in the brain. The nonspecific white matter changes may indicate potential changes in the brain (Pagana et al., 2021). The resolved occlusion shows that there is no blockage in the blood vessels or arteries. These results indicate that

				the TIA caused temporary effects to the client and have resolved (Capriotti, 2024).
		CT Stroke Head Without Contrast: This diagnostic provides a 3D view of the cranial contents. It may be utilized to diagnosis cerebral infarctions while viewing the variations in density of the brain tissue (Pagana et al., 2021).	The client experienced slurred speech, headaches, blurred vision, numb lips and weaknesses.	The results showed that there are no intracranial changes or abnormalities. However, there is an old infarct versus a perivascular space which may be evidence of a previous stroke or

				minor damage (Pagana et al., 2021). There are white matter changes, however, that is mostly likely due to natural aging. An MRI would be beneficial for clarification, however, the client refused. These results show that the clients TIA was not related to a major

				occlusion or a potential new stroke (Capriotti, 2024).

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2024). *Pathophysiology, Introductory Concepts and Clinical Perspectives. (3rd Edition).* Davis Advantage.

Pagana, K. D., Pagana, T. J. & Pagana, T. N (2021). *Mosby's Diagnostic & Laboratory Test Reference (15th Edition).* Elsevier.

Active Orders

Active Orders	Rationale
Adult Diet. Diet Type: Modified Texture; Liquid Consistency: Thin; solid consistency: Soft bite-sized; Select tray type: Aspiration Precaution	Client presents concern for potential aspiration.
Diet Supplement Other	The client needs Ensure shakes during breakfast, lunch, and dinner for supplemental support.
IP Consult to Neurology Tele-Neuro Hospitalist	The client was admitted to having a suspected stroke/TIA.
CMP, CBC, Mg, POCT, INR	The physician wanted daily current lab

	values. Preform POCT and INR from protime (PT) if available for patients on anticoagulants or dialysis.
PT, OT, SLP therapy	Client needs evaluation and treatment for suspected stroke and is an aspiration risk.
Pulse Oximetry spot	This is used to determine the initial blood oxygen to make sure they do not need supplemental oxygen.
Admission Weight	A one-time nurse discretion scale to determine a baseline value and for medication doses.
Cardiac Monitoring	This is needed to monitor cardiac activity and any irregularities.
Insert/Maintain Peripheral IV	This is needed to give and access medications, monitor fluids and emergency situations.
Intake and Output	This is used to monitor intake and output to watch for fluid retention or constipation.
Maintain IV while on Telemetry	The IV should be locked and flushed with saline before and after push for patience.
NIH Stroke Scale	This is used continuously to assess any acute neurological changes.
Notify Physician	Notify physician for bradycardia (<50),

	tachycardia (>120), bradypnea (<10), tachypnea (>30), hyperthermia (>101.5F), systolic <85 and >105, diastolic <50 and >105, SpO2 <90% and new or consistent pain. Symptomatic bradycardia, ventricular arrhythmias, prior medication review. Medication route changes when the SpO2 is <94% or the temp is < or = 100.4F.
Nursing Communication	Maintain SBP less than 220, offer prune juice which is available on their diet. Provide nutritional education to prevent and reduce constipation such as red meat, fried/fatty foods, milk and cheese. Promote adequate fluid intake and encourage fluid increase.
Nursing Night Calls	If the IV expires, leave it until the physician arrives at 0700. Adress morning lab questions from 0700-1500. If house wide telemetry expires, remove and return to pack 4. Nonviolent restraint orders renewals only from 1900-2359 if the renewal is not in place otherwise, leave it in place.
Patient education: Provide stroke education material to the patient and family	Obtain Modified Rankin Score prior to new stroke symptoms and at discharge. NIH

	patient education provided stroke information to the patient and family.
Patient may shower	The client may shower to maintain hygiene with assistance.
Preform POC Blood Glucose	One time occurrence to evaluate glucose at above 400 or below 40.
PHQ2 Depression Screen on Admission	This is used to screen for depression on admission with flowsheet.
RN Aspiration risk tool screening	This is used for assessing risk for aspiration.
Sequential Compression Device	This is used to increase vascular return for the lower extremities.
Up as tolerated	Physical movement is imperative to rebuild and maintain muscle strength after CVA.
Vital Signs	Vital signs are gathered every hour to monitor the patients current status.

Hospital Medications (Must List ALL)

Brand/Generic	Aspirin/ acetylsalicylic acid	Aspirin/ acetylsalicylic acid	Plavix/clopidogrel bisulfate	Lexapro/ escitalopram oxalate
Dose, frequency, route	~ 81mg chewable tablet ~ once daily ~ oral	**~** 300 mg tablet ~ once daily until discharged **~** suppository is an alternative to oral if oral is unavailable.	~75mg tablet ~once daily ~oral	~10mg tablet ~ once daily **~** oral
Classification	Pharmacological	Pharmacological	Pharmacological	Pharmacological

(Pharmacological and therapeutic and action of the drug	class: Salicylate Therapeutic class: NSAID ~Aspirin forces the platelets to stop sticking together by blocking the thromboxane A2 substance. Thromboxane is what makes the platelets create a clot.	class: Salicylate Therapeutic class: NSAID ~Aspirin forces the platelets to stop sticking together by blocking the thromboxane A2 substance. Thromboxane is what makes the platelets create a clot.	class: P2Y^12 platelet inhibitor. Therapeutic class: Platelet aggregation inhibitor. ~clopidogrel stops platelets from sticking together by blocking ADP receptors which prevents the formation of thrombi.	class: Selective serotonin Therapeutic class: Antidepressant Lexapro inhibits reuptake of the neurotransmitter serotonin by the CNS neurons which boosts the mood while lowering anxiety.
Reason Client Taking	This antiplatelet is used to help prevent blood from clotting and causing future CVAs.	This antiplatelet is used to help prevent blood from clotting and causing future CVAs.	This antiplatelet is used to help prevent blood from clotting and causing future CVAs.	The client has a history of anxiety which may be uncontrollable for her, Lexapro helps control her anxiety.
Two contraindications (pertinent to the client)	**1.** Increased risk of bleeding **2.** Potential coagulation disorder	**1.** Increased risk of bleeding **2.** Potential coagulation disorder	**1.** Increased risk of bleeding **2.** Increased risk for peptic ulcers	**1.** Increased risk of bleeding **2.** May affect any underlying heart conditions
Two side effects or adverse effects (Pertinent to the client)	**1.** Confusion since it is a CNS depressant **2.**Decreased blood iron level	**1.** Confusion since it is a CNS depressant **2.**Decreased blood iron level	**1.** Increased risk of bleeding **2.** Potential elevated serum creatinine levels	**1.** Abnormal gait **2.**Increased anxiety or confusion
Key nursing assessment(s) prior to administration	**1.**Assess both renal and hepatic function. **2.**Reveiw CBC to review hemoglobin and hematocrit.	**1.**Assess both renal and hepatic function. **2.**Reveiw CBC to review hemoglobin and hematocrit.	**1.** Review CBC levels to check the platelet count and hemoglobin and hematocrit **2.** Assess any potential bleeding in urine, small	**1.**Assess previous mental health history **2.** Assess and monitor electrolytes and vital signs.

			continuous cuts, bruising or occult blood	

Brand/Generic	Synthroid/levothyroxine	Xarelto/ rivaroxaban	Zocor/ simvastatin	Tylenol/ acetaminophen
Dose, frequency, route	~ 25 mcg tablet ~ every morning before breakfast ~ oral	~2.5 mg tablet ~ 2 times daily with meals ~ oral	~ 40 mg tablet ~ every day at night ~ oral	~ 650 mg tablet (max dose 400mg/24hrs) ~ PRN Q4H ~for mild or sever pain per request ~ oral
Classification (Pharmacological and therapeutic and action of the drug	Pharmacological class: Synthetic thyroxine Therapeutic class: Thyroid hormone replacement The thyroid hormone thyroxine supplements the thyroid hormone in cases when the body's thyroid is unable to create the proper amount.	Pharmacological class: Factor Xa inhibitor Therapeutic class: Anticoagulant It blocks Factor Xa, which is an important part in blood clotting and decreases the clotting process. This essentially reduces the chances of a stroke or TIA.	Pharmacological class: HMG-CoA reductase inhibitor (statin) Therapeutic class: Antilipemic Zocor blocks the HMG-CoA enzyme which slows down the production of cholesterol that the liver makes. This then lowers the amount of cholesterol in the bloodstream.	Pharmacological class: Nonsalicylate, para-aminophenol derivative Therapeutic class: antipyretic, nonopioid analgesic Tylenol inhibits cyclooxygenase which resolves pain and reduces fevers.
Reason Client Taking	The client needs to take Synthroid for her thyroid hormone replacement therapy for her insufficient thyroid.	The client needs to reduce the risk of blood clots and prevent the recurrence of another CVA/TIA. Xarelto is a blood thinner and prevents blood clots.	The client has high cholesterol and Zocor can lower the levels which will then help reduce the risk for strokes.	Tylenol should be given when the client presents mild to moderate pain.
Two contraindications (pertinent to the	**1.** Increased possibility of cardiovascular problems such as	**1.**Active pathological bleeding	**1.**The client may be at risk for liver disease since Zocor affects the	**1.**Severe active liver disease or impairment

client)	arrhythmia **2.** Closely monitor mental health, mood changes, anxiety or depression.	 **2.**Hypersensitivity to Xarelto or the components within it	liver function. **2.** The client may be at risk for severe renal impairment	 **2.**Potential risk for renal impairment
Two side effects or adverse effects (Pertinent to the client)	**1.**Respirtory changes such as dyspnea or wheezing. **2.**Seizures and tremors	**1.**Risk for cerebral hemorrhage **2.** Unusual bruising or bleeding in stool or urine	**1.** Statin induced myopathy **2.**Urinary tract infections	**1.**hypotension or hypertension **2.**peripheral edema
Key nursing assessment(s) prior to administration	**1.**Closely monitor blood pressure to prevent another CVA/TIA **2.**Monitor signs of hyperthyroidism or hypothyroidism to ensure the drug is working effectively.	**1.** Look for any potential bleeding in urine or stool as well as any bruising. **2.** Assess renal and liver function to ensure proper function. A CBC will be helpful when assessing lab values as well.	**1.**Monitor liver and renal functions since statins have the ability to affect the liver **2.**Assess nutritional intake and balance since the diet may be the cause of cholesterol levels.	**1.**Assess pain scale by using the numeric rating scale. **2.** Assess nutrition since poor nutrition may lead to hepatotoxicity.
Brand/Generic	Tums/ calcium carbonate	Apresoline/ hydralazine hydrochloride	Normodyne; Trandate/ labetalol	Melatonin/ circadian(sp)
Dose, frequency, route	~ 1,000mg ~ PRN Q8H ~ oral chewable	~10 mg ~PRN Q4H ~ injection	~ 10 mg ~ PRN nightly ~ injection	~ 6 mg ~PRN nightly ~oral
Classification (Pharmacological and therapeutic and action of the drug	Pharmacologic class: Calcium salts Therapeutic class: Antacid Tums neutralize gastric acid which may help relieve indigestion and heartburn.	Pharmacologic class: Vasodilator Therapeutic class: Antihypertensive Hydralazine inhibits the calcium ions which causes the walls of the blood vessels to dilate which reduces the blood pressure.	Pharmacologic class: Noncardioselective beta-blocker/alpha 1-blocker Therapeutic class: Antihypertensive Labetalol blocks the alpha and beta receptors and lowers the heart rate and pressure at which the heart pumps. This	Pharmacologic class: Chronobiotic Therapeutic class: Antioxidant Melatonin binds to the MT1 and MT2 receptors which helps regulate sleep patterns.

			lowers the blood pressure since the blood vessels are being dilated.	
Reason Client Taking	The client may take Tums during the occurrence of heartburn or indigestion.	The client uses hydralazine to lower her blood pressure which may reduce the risk for further strokes.	Labetalol is used to help regulate and control the clients hypertension.	The client needs to take melatonin as needed to help regulate sleep patterns and get a good night's rest.
Two contraindications (pertinent to the client)	**1.**May result in hypercalcemia from concurrent use of calcium supplements. **2.**Do not take more than recommended because it may cause the gastric pH balance to rise and make the stomach contents more acidic.	**1.** If the blood pressure is low and the medication is given it may cause severe hypotension. **2.** The client may experience hypersensitivity	**1.** If the blood pressure is low and the medication is given it may cause severe hypotension. **2.** Risk for potential cardiogenic shock	**1.** Bleeding disorder and risk for increased bleeding. **2.** Potential depression
Two side effects or adverse effects (Pertinent to the client)	**1.**Potential dehydration **2.** lightheadedness and flushed face	**1.** Potential edema **2.** Potential orthostatic hypotension	**1.**Potental bradycardia **2.** Possible orthostatic hypotension	**1.** Daytime drowsiness **2.** Severe vivid dreams or nightmares
Key nursing assessment(s) prior to administration	**1.**Inspect and auscultate the abdomen to assess for any constipation. **2.** Space out Tums when taking other medications preferably 1-2 hours apart.	**1.** Assess blood pressure before administering medication **2.** Instruct the client how to administer hydralazine	**1.** Assess blood pressure before administering medication **2.** Instruct the client to dangle feet before attempting to stand with assistance to ensure proper blood pressure regulation.	**1.**Discover underlying sleep problems. **2.** Take 30-60 mins before bedtime while taking the correct dosage.
Brand/Generic	Zofran -ODT/ Ondansetron	Ativan/lorazepam	MiraLAX/polyethylene glycol	

Dose, frequency, route	~ 4 mg tablet ~ PRN Q6H ~ oral disintegrating or injection	~ 0.5 mg tablet ~ PRN nightly ~ oral	~ 17g packet ~ PRN 2 times daily ~ oral
Classification (Pharmacological and therapeutic and action of the drug	Pharmacological class: Selective serotonin (5-HT3) receptor antagonist Therapeutic class: Antiemetic Zofran blocks the 5-HT3 receptors and blocking these reporters prevents nausea and vomiting.	Pharmacological class: Benzodiazepine Therapeutic class: Anxiolytic Ativan binds to the GABA receptors which results in a calming of the nervous system and reduces anxiety.	Pharmacological class: Osmotic laxative Therapeutic class: laxative MiraLAX uses an osmotic effect to pull water into the color and softens the stool to make defecation easier.
Reason Client Taking	The client should take Zofran as needed for nausea.	The client will take Ativan as needed for anxiety control.	The client will take MiraLAX as needed to soften stool while defecating.
Two contraindications (pertinent to the client)	**1.** The client may have potential electrolyte imbalances. **2.** Potential hypersensitivity reactions.	**1.** Do not use it if blood pressure is low. **2.** Potential cognitive impairment	**1.** Only use when needed because it may result in constipation. **2.**Potential bowel obstruction may worsen the blockage.
Two side effects or adverse effects (Pertinent to the client)	**1.**Potential hypotension and weakness. **2.**Headaches and dizziness	**1.** Potential respiratory depression **2.** Possible anxiety, depression and drowsiness.	**1.** The client may experience fluid electrolyte imbalance. **2.** The client may experience abdominal pain if the blockage does not pass which may lead to future complications.
Key nursing assessment(s) prior to administration	**1.**Ensure electrolyte balance before administering Zofran. **2.**Monitor client or chest pain and any abnormal changes or	**1.** Instruct the client to keep naloxone on hand in case an overdose occurs. Gradually taper medication doses	**1.** Encourage and mix the powder with a liquid drink to maintain fluids so the fluids can soften the obstruction in the bowls.

	reactions.	to allow the body to slowing minimize withdrawal symptoms. **2.** Monitor blood pressure and respiratory status since benzodiazepines may slow the respiratory system.	**2.** Drink plenty of fluids to prevent electrolyte imbalance and dehydration.

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Clopidogrel (Plavix)	This antiplatelet is used to help prevent blood from clotting and causing future CVAs.	**1.** Increased risk of bleeding **2.** Potential elevated serum creatinine levels
2. Aspirin	This antiplatelet is used to help prevent blood from clotting and causing future CVAs.	**1.** Increased risk of bleeding **2.** Potential coagulation disorder

3. Rivaroxaban (XARELTO)	The client needs to reduce the risk of blood clots and prevent the recurrence of another CVA/TIA. Xarelto is a blood thinner and prevents blood clots.	**1.**Risk for cerebral hemorrhage **2.** Unusual bruising or bleeding in stool or urine

Medications Reference (1) (APA)

Jones & Bartlett Learning. (2025). *Nurse's Drug Handbook.*

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions:** **Client Complaints or Concerns:**	The client appears alert and oriented x4, well groomed no acute distress. No infection control precautions and client states that she has no complaints or concerns.
VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	Time: 0728 Temperature: 96.2 F. Respiratory rate: 15 breaths per min Pulse: 77bpm right radial B/P: 149/57 mm/Hg upper right arm Oxygen: 95% spO2 on room air
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:** **Interventions:**	Time: 1715 Scale: 0-10 Numeric Location: none Severity: 0/10 Characteristics: none Interventions: none
IV ASSESSMENT: **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:**	Size of IV: 22g Location of IV: left antecubital Date on IV: 9/6/25 Patency of IV: line flushes easily without resistance and blood return is confirmed. No phlebitis, extravasation, infiltration or infection

IV dressing assessment: **Fluid Type/Rate or Saline Lock:**	suspected. IV dressing assessment: clean, dry and intact with transparent dressing. Fluid Type/Rate or Saline Lock: Potassium Chloride IVPB at 50mL/hr. (100ml) 0.9% Normal Saline was then discontinued at 1000.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Skin color: Peachy/pink Character: pigmented spots and uneven texture on arms. +2 edema bilaterally in ankles. Temperature: All extremities warm Turgor: slow return, >3 seconds Rashes: none Bruises: none Wounds: none Braden Score: 15 Drains present: none Type: N/A
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck: Symmetrical, trachea is midline without any deviation and no lumps or bumps noted. Carotid pulses palpable individually while being +2. Ears: Bilateral auricles with no notice or palpable abnormalities. No signs of drainage and the client has some trouble hearing. Eyes: Bilateral sclera white, cornea clear, conjunctiva pink and no noticed drainage. Eye lids are pink, and PERLA and EOMS are intact. Nose: Nostrils are moist and pink with no drainage or bleeding and septum is midline. Frontal sinuses are not sensitive when palpated bilaterally. Teeth and Mouth: Uvula midline, posterior pharynx and tonsils are moist. The hard palate and soft palate are intact. Teeth are good and partial upper denture is in place. No signs of drainage or bleeding.
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:**	There were clear S1 and S2 heart sounds noted with no signs of murmurs, gallops or rubs. All extremities are pink, warm and dry. Upper extremities pulses are 2+ and the lower extremities pulses are 1+ due to the +2 edema in the ankles. No upper extremity edema noted. Capillary refill is less than 3 seconds on both toes and fingers. No signs of JVD bilaterally.

RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Accessory muscle use: none Breath Sounds: There is a normal rate and pattern of non-labored breathing. There are clear lung sounds and no signs of wheezes, crackles or rhonchi, anterior and posterior bilaterally.
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 ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Diet at home: The clients diet consists of bananas, breakfast sandwiches without the bread and sausage, frozen meals and turkey burgers. Current Diet: Adult Diet. Diet type: Modified Texture; liquid consistency; Thin; Solid consistency: Pureed; Select tray type: Aspiration Precaution, 1:1 feeding, diet. Ensures are also needed three times daily for dietary support. The client is tolerating the diet well; however, her home diet should be improved. Height: 5ft 1in Weight: 140lbs Auscultation Bowel sounds: normoactive in all 4 quadrants Last BM: 9/7/25 Palpation: Pain, Mass etc.: Abdomen is soft, and non-tender with no masses noted in all 4 quadrants. Light and deep palpation performed with no abnormalities. Inspection: Client's abdomen appears to be slightly rounded. Distention: none Incisions: none Scars: none noticed Drains: none Wounds: none Ostomy: none Nasogastric: none Feeding tubes/PEG tube: none
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Color: light yellow Character: clear, mild odor with no sediment Quantity of urine: 600 mL charted Pain with urination: No Dialysis: No Inspection of genitals: N/A Catheter: Yes Type: External PureWick Size: Standard

Intake (in mLs) **Output (in mLs)**	Charted Intake: 240mL at 0840 240mL at 1200 Total 480mL Charted Output: 200mL at 0700 400mL at 1730 Total 600mL
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	Neurovascular status: The client's skin temperature is warm and the nail beds are intact pink and has a capillary refill of less than 3 seconds. ROM: The client is able to perform active ROM however passive ROM is performed. Refused to turn every 2 hours. Supportive devices: Quad cane and walker used for support. Strength: Hand grips, pushes and pulls are bilaterally equal. Pedal pushes and pulls display uneven strength. Right foot has decreased strength compared to the left foot on both pedal pushes and pulls. Active motion against gravity (level 3). ADL Assistance: Yes Fall Risk: Yes Fall Score: 80 Morse Fall Scale Activity/Mobility Status: Has the ability to move arms and legs in bed however, unable to scoot up in bed and get out of bed without assistance. Activity Tolerance: tolerates well Needs assistance with equipment: Yes Needs support to stand and walk: Yes
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW: Intact PERLA: Intact Strength Equal: No Legs ☒ Arms ☐ Both ☐ Orientation: Alert and orientated x4 Mental Status: Intact – good memory considering age Speech: speaks softly and clearly Sensory: reacts to stimuli correctly (light touch and sharp) LOC: Alert: arouses when entering the door and answers questions quickly and appropriately.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:**	Coping method(s): Uses distraction method when feeling anxious and has accepted the thought of death and states that she "wants to die so she can

Religion & what it means to pt.: **Personal/Family Data (Think about home environment, family structure, and available family support):**	be with her husband again". Developmental level: The client is able to read full sentences. Writing level was not examined. Religion & what it means to pt.: Christian and states that she "serves the lord and try's to do the right thing". Personal/Family Data: Client has supportive family that alternates visiting her in the hospital and her daughter checks in on her at home every other day. The family supports decisions that the client makes but provides ideas and suggestions for the client to make the decision. A home health nurse will be coming to her home daily to help with ADLs and any medical assistance to ensure her safety and well-being. The client has an exceptionally supportive family.

Discharge Planning

Discharge location: The client verbally stated that she was going to attend therapy and then return to her home where she will live alone.

Home health needs: She will have a home health nurse come every day to assist in activities of daily living as well as assistance in any medical needs.

Equipment needs: She will need her quad cane, walker, partial dentures and reading glasses.

Follow up plan: The client will attend physical therapy to help manage her strength and condition as well as attending follow-up appointments with her physician for regular health monitoring.

Education needs: The client needs to understand the importance of nutritional support. Her diet consists of bananas, breakfast sandwiches without the bread or sausage, frozen meals and turkey burgers. Proper low sodium and high protein diets should be considered for the client and home prepared meals would be beneficial for her as well.

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**
1. Imbalanced Nutrition related to unhealthy eating habits as evidence by living alone and struggling to perform activities of daily living.	The client discussed her eating habits and expressed concern regarding her selective food choices. She has difficulties mobilizing and chooses to eat simple meals such as bananas and microwave meals. These choices may lead to an imbalanced nutrition and the need for supplemental support.	The client will drink Ensure supplementals three times daily for three months to increase her nutritional quality and follow up with her primary care provider.	**1.** The client will create a nutritional journal to document her nutritional intake. This will create a charted view of portion control, time and caloric intake. **2.** Provide proper education on adequate nutrition and the health benefits of eating healthy. The client will participate in meal prepping on Sundays for three months	The client and family will demonstrate an understanding of the importance of adequate nutrition intake by presenting their nutritional journal at the end of the three month period. The client will discuss meal preparation and any concerns.

			with her daughter to ensure a balanced nutritional diet.	
2. Impaired Physical Mobility related to neuromuscular impairment as evidence by CVA/TIA and peripheral edema.	The client has difficultly mobilizing as a result of the ischemic stroke and previous strokes. The blood flow to her brain was interrupted during the stroke which may have resulted in focal motor weakness in her right foot. The +2 edema in her ankles and feet may also be considered for impaired physical mobility.	The client will demonstrate maintained physical mobility with joint range of motion as well as attending physical therapy at least 3 times per week to show visible improvement. The client will be able to mobilize from the bed to her chair by the end of the first month of physical therapy.	**1.** Place the client in pneumatic compression devices for the +2 edema in her lower extremities to increase vascular return. **2.** All personal items will be placed on the clients bedside table to ensure safety and to protect her from any potential falls.	The client tolerated the application of the pneumatic compression devices on her lower extremities well. She expressed thanks while they were being applied. Her personal belongings were placed on the bedside table where she was able to reach her items with ease.
3. Decreased Activity Tolerance related to impaired physical mobility as evidence by CVA/TIA.	The client is unable to perform activities of daily living which are related to the cerebrovascular accident. She is unable to provide proper self-care independently and her activity tolerance and muscle strength	The client will describe the desire to increase her activity level and demonstrate the understanding of performing self-care activities independently. Before she is discharged from the	**1.**Provide education to the client about the importance of strength training and how it relates to the endurance of self-care. **2.** Provide encouragement to the client and assist in	The client understood the importance of proper strength training and believes that she is able to improve. Together we discussed activity progression, and the client showed passion in wanting to be

	is decreased.	hospital, she will demonstrate the teach back method to verbally describe her understanding of this goal.	planning activity progression, while including the activities that the client believes to be considered essential.	able to shower alone.

Nursing Process Prioritization	**Rationale**
1. Imbalanced Nutrition related to unhealthy eating habits as evidence by living alone and struggling to perform activities of daily living.	The client discussed her eating habits and expressed concern regarding her selective food choices. She has difficulties mobilizing and chooses to eat simple meals such as bananas and microwave meals. These choices may lead to an imbalanced nutrition and the need for supplemental support.
2. Impaired Physical Mobility related to neuromuscular impairment as evidence by CVA/TIA and peripheral edema.	The client has difficultly mobilizing as a result of the ischemic stroke and previous strokes. The blood flow to her brain was interrupted during the stroke which may have resulted in focal motor weakness in her right foot. The +2 edema in her ankles and feet may also be considered for impaired physical mobility.
3. Decreased Activity Tolerance related	The client is unable to perform activities of

to impaired physical mobility as evidence by CVA/TIA.	daily living which are related to the cerebrovascular accident. She is unable to provide proper self-care independently and her activity tolerance and muscle strength is decreased.

Other References (APA):

Phelps, L. (2021). *Nursing Diagnosis Reference Manual.* (12th edition). Wolters Kluwer.