

N311 Care Plan 3

Marc Villaester

Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Dowell

September 28, 2025

Demographics

Date of Admission 9/23/25	Client Initials RGB	Age 84	Biological Gender Male
Race/Ethnicity White	Occupation Retired	Marital Status Single	Allergies None
Code Status DNR	Height 6' 2"	Weight 283lbs	

Medical History

Past Medical History: Actinic keratitis, age-related nuclear cataract of left eye, age-related nuclear cataract of right eye, bladder cancer, bladder neoplasm, benign prostatic hyperplasia, diastolic dysfunction, hypercholesterolemia, hypertension, obesity, prostate-specific antigen elevation, urinary calculi

Past Surgical History: Wisdom teeth removal, rotator cuff repair, bladder surgery, colonoscopy (04/2015), cataract removed with implant (left, 9/10/2020), and cataract removal with implant (right, 9/17/2020)

Family History: Older sister - Alzheimer's, Father - heart disease

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

Patient has a history of smoking cigarettes. Patient smoked for 40 years, smoking around two packs per day. The patient has since quit for 25 years. Patient drinks 1-2 beer cans around once a week. Patient denies any use of recreational drugs.

Education: Master's in business

Living Situation: Individually at home

Assistive devices: Walker, reading glasses

Admission Assessment

Chief Complaint: Blurred vision

History of Present Illness (HPI) – OLD CARTS:

Patient was admitted to the hospital by ambulance from the eye clinic. Patient stated that he fell last Wednesday and hit his head. Patient stated that he experienced blurry vision for several hours, noting that he only had “ $\frac{2}{3}$ ” of his vision. Upon falling, the patient felt confused and scared. Patient stated that nothing aggravated his vision/pain. Patient did not try any at-home treatment or over-the-counter medications.

Primary Diagnosis

Primary Diagnosis on Admission: Cerebral Vascular Accident (CVA)

Secondary Diagnosis (if applicable):

Pathophysiology

Pathophysiology of the Disease, APA format:

Cerebral vascular accident (CVA) is primarily found in the form of acute ischemic stroke (IS), which accounts for approximately 85% of cases (Guo et al., 2014). This is caused by a blockage or interruption of cerebral blood flow (Maida et al., 2024). This interruption of blood flow triggers a destructive snowball effect, involving severe energy metabolism disorders and cellular acidosis (Wu et al., 2020). Key molecular events that cause cellular death in neural cells include glutamate-induced excitotoxicity and reactive oxygen species-mediated oxidative stress (Wu et al., 2020). A stroke creates a permanently damaged core area, surrounded by the penumbra, tissue with low blood flow but potentially salvageable (Wu et al., 2020). Diagnosis depends on quickly ruling out bleeding with a non-contrast computer tomography (CT) scan, then using further imaging to identify the penumbra and guide treatment (Wu et al., 2020).

As the ischemic process evolves, two zones develop: the infarct core, an irreversibly damaged region of brain tissue, and the ischemic penumbra, a surrounding area that is severely lacking blood flow, however potentially salvageable with immediate intervention (Maida et al., 2024). The penumbra represents the target for acute stroke therapies to restore perfusion and minimize long-term deficits (Maida et al., 2024). If untreated, progressive excitotoxicity and oxidative stress cause the penumbra to collapse into the infarct core, worsening disability (Maida et al., 2024).

In this patient, the stroke involved the posterior cerebral artery, as confirmed by the non-contrast CT scan, showing a significant blockage in the left posterior cerebral artery (PCA) and narrowing of the right PCA. This translated to the patient's blurred vision and partial field of vision loss. Additionally, this was also shown in his weakness in the lower extremities,

increasing the potential risk for falls. These symptoms correlate with ischemic injury in the occipital lobe and neighboring vascular areas (Hamblen, 2023).

Diagnosis of IS was established through neuroimaging. A non-contrast CT scan ruled out acute hemorrhage or extra-axial fluid collection, which is important to ensure the effectiveness of reperfusion therapies (Maida et al., 2024). Additional magnetic resonance imaging confirmed ischemic injury without bleeding, supporting the diagnosis of acute IS. These findings, in combination with the patient's chief complaint and symptoms, confirm the presence of CVA.

Pathophysiology References (2) (APA):

Guo, Y., Li, P., Guo, Q., Shang, K., Yan, D., Du, S., & Lu, Y. (2014, January). Pathophysiology and Biomarkers in Acute Ischemic Stroke – A Review. ResearchGate.

https://www.researchgate.net/publication/272326198_Pathophysiology_and_Biomarkers_in_Acute_Ischemic_Stroke_-_A_Review

Maida, C. D., Norrito, R. L., Rizzica, S., Mazzola, M., Scarantino, E. R., & Tuttolomondo, A.

(2024, June 7). Molecular pathogenesis of ischemic and hemorrhagic strokes:

Background and therapeutic approaches. MDPI. <https://www.mdpi.com/1422-0067/25/12/6297>

Wu, L., Xiong, X., Wu, X., Ye, Y., Jian, Z., Zhi, Z., & Gu, L. (2020, March 4). Targeting

oxidative stress and inflammation to prevent ischemia-reperfusion injury. *Frontiers*.

<https://www.frontiersin.org/journals/molecular-neuroscience/articles/10.3389/fnmol.2020.00028/full>

Hamblen, M. (2023, November 13). CT angiography head and neck: Indications and limitations.

emDocs. <https://www.emdocs.net/ct-angiography-head-and-neck-indications-and-limitations>

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Sodium	133mmol/L	134mmol/L	136- 145mmol/L	Duretic medications
Potassium	3.6mmol/L	3.4mmol/L	3.5-5.1mmol/L	Diuretic medications
Chloride	100mmol/L	96mmol/L	98-107mmol/L	Low sodium = drop in chloride
Glucose	210mg/dL	175mg/dL	70-99mg/dL	Elevation due to hormones released in sympathetic nervous system (SNS)
Triglycerides	191mg/dL	Not in chart	<150mg/dL	Elevation due to hormones released in the SNS
HDL Cholesterol	33mg/dL	Not in chart	>40mg/dL	Sedentary lifestyle
Chol/HDL Ratio	5.2	Not in chart	0.0-4.4	SNS releases cortisol + adrenaline = triggers lipid metabolism
Non-HDL Cholesterol	139mg/dL	Not in chart	<130mg/dL	Atherosclerosis d/t elevated cortisol
Mean	80.8fL	80.2fL	82.0-96.0fL	Poor nutrition

Corpuscular Volume				
-----------------------	--	--	--	--

Diagnostic Test & Purpose	Clients' Signs and Symptoms	Results
Computed Tomography Angiography Head and Neck - Common evaluation method for patients presenting with acute ischemic stroke symptoms (Hamblen, 2023)	Vision loss/weakness in legs	Large blockage in the left posterior cerebral artery (PCA), partial blood flow reaching areas beyond the blockage. Right PCA is experiencing a severe narrowing in P2 segment, complete blockage in P3-P4 branches
MRI Brain W/O Contrast - used to detect the presence of a stroke	Vision loss/weakness in legs	No signs of bleeding or fluid buildup in the brain

Diagnostic Test Reference (1) (APA):

Hamblen, M. (2023, November 13). CT angiography head and neck: Indications and limitations. emDocs. [https://www.emdocs.net/ct-angiography-head-and-neck-indications-and-limitations/#:~:text=One%20of%20the%20most%20common%20uses%20of,vascular%20lesion%20amenable%20to%20mechanical%20thrombectomy%20\(MT\).](https://www.emdocs.net/ct-angiography-head-and-neck-indications-and-limitations/#:~:text=One%20of%20the%20most%20common%20uses%20of,vascular%20lesion%20amenable%20to%20mechanical%20thrombectomy%20(MT).)

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.

<p>GENERAL:</p> <p>Alertness: Fully alert</p> <p>Orientation: Fully oriented</p> <p>Distress: No signs of distress</p> <p>Overall appearance: Well-groomed</p>	<p>Patient fully alert and oriented ×4. No signs of distress noted. Overall appearance is well-groomed.</p>
<p>MUSCULOSKELETAL:</p> <p>Neurovascular status: Alert/Oriented</p> <p>ROM: Full active range of motion</p> <p>Supportive devices: Walker</p> <p>Strength: Grips equal bilateral, foot pushes equal bilateral</p> <p>ADL Assistance: No</p> <p>Fall Risk: Yes</p> <p>Fall Score: 82</p> <p>Activity/Mobility Status: As tolerated</p> <p>Independent (up ad lib) Yes</p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p>	<p>Neurovascular status intact. Full active ROM in all extremities. Strength is equal bilaterally with strong hand grips and foot pushes. Patient ambulates with a walker. No assistance required with activities of daily living. Morse Fall Score = 75 (high risk). Activity/mobility as tolerated, independent up ad lib.</p>
<p>NEUROLOGICAL:</p> <p>MAEW: Yes</p> <p>PERLA: Yes</p> <p>Strength Equal: Yes</p> <p>Orientation: Fully aware</p> <p>Mental Status: Alert, awake, talkative</p> <p>Speech: Clear, easy to understand</p>	<p>Patient alert, awake, and talkative. MAEW, PERLA present. Strength is equal bilaterally. Oriented ×4. Speech was clear and easily understood. Sensory intact to light palpation. Level of consciousness is fully aware.</p>

<p>Sensory: Can feel light palpation</p> <p>LOC: Fully aware</p>	
<p>PSYCHOSOCIAL/CULTURAL:</p> <p>Coping method(s): Family/watching sports on television</p> <p>Developmental level: Mature</p> <p>Religion & what it means to pt.: Non-religious</p> <p>Personal/Family Data (Think about home environment, family structure, and available family support): Lives alone, parents are deceased, has two sisters, of whom the oldest is deceased. Available family support includes a younger sister.</p>	<p>Coping methods include family support and watching sports on television. Developmental level is mature. Non-religious. Lives alone; both parents deceased. Has two sisters, one deceased; younger sister available for support.</p>
<p>FALL SCALE (MORSE):</p> <p>Fallen Before: +25</p> <p>Fallen Recently: +25</p> <p>Walker: +15</p> <p>Weak Gait: +10</p> <p>Total: 75 (High Risk)</p>	<p>Score: 75 (high risk). Risk factors: history of falls, recent fall, use of a walker, weak gait.</p>
<p>BRADEN SCALE:</p> <p>Sensory Perception: 4 (no impairment)</p> <p>Moisture: 4 (rarely moist)</p> <p>Activity: 2 (chairfast)</p> <p>Mobility: 2 (very limited)</p> <p>Nutrition: 3 (adequate)</p> <p>Friction and Shear: 3 (no apparent problem)</p> <p>Total: 20 (Low risk for pressure ulcers)</p>	<p>Score: 20 (low risk for pressure ulcers). Sensory perception: 4, moisture: 4, activity: 2 (chairfast), mobility: 2 (very limited), nutrition: 3 (adequate), friction/shear: 3.</p>

Vital Signs, 1 set – **HIGHLIGHT ALL ABNORMAL VITAL SIGNS**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
------	-------	-----	-----------	------	--------

0700	85bpm	151/86mmHg	18RR	97F	91%
------	-------	------------	------	-----	-----

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
0832	RASS	Legs	3	Weakness	Assisting with mobility (wheelchair, gait belt, etc.)

Intake and Output

Intake (in mL)	Output (in mL)
300mL Oral (Drinking Water)	250mL Urine

Nursing Diagnosis

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
<ul style="list-style-type: none"> ● Include full nursing diagnosis with “related to” and “as evidenced by” components ● Listed in order by priority – highest priority to lowest 	<ul style="list-style-type: none"> ● Explain why the nursing diagnosis was chosen 			<ul style="list-style-type: none"> ● How did the client/family respond to the nurse’s actions? <ul style="list-style-type: none"> ● Client response, status of goals and outcomes, modifications to plan.

priority, pertinent to this client				
1. High risk of fall related to CVA as evidenced by weakness in lower extremities	Strokes often damage regions in the brain that are responsible for motor control, leading to reduced mobility (Lee et al., 2022)	1. Assist the patient with both passive and active range of motion exercises to maintain joint flexibility and prevent contractures 2. Educate the patient on using assistive devices such as walkers	1. Within 7 days, the patient will be able to transfer from bed to chair with only minimal assistance in at least 3 out of the 5 attempts	Before the 7 days, the patient was able to transfer from bed to chair with minimal assistance. Additionally, the patient was able to ambulate with a walker without assistance.
2. Risk for aspiration related to impaired swallowing d/t CVA	Stroke commonly impairs a patient's mechanisms for swallowing, therefore increasing the risk of aspiration (Elsyaad et al., 2022)	1. Maintain the patient in high Fowler's when intaking food 2. Collaborate with the doctor in determining a recommended diet consistency	1. The patient will tolerate oral intake without coughing, choking, or showing signs of aspiration over the next 3 consecutive days	Before discharge, the patient had no problems eating or drinking, showing no signs of aspiration or any difficulty in performing those actions

Other References (APA):

Lee, K. E., Choi, M., & Jeung, B. (2022, October 5). Effectiveness of rehabilitation exercise in improving physical function of stroke patients: A systematic review. MDPI.
https://www.mdpi.com/1660-4601/19/19/12739?utm_source=chatgpt.com

Elsyaad, M. S. A., Fayed, A. M., Megahed, M. M. A. S., Hamouda, N. H., & Elmenshawy, A.

M. (2022, June 27). Early assessment of aspiration risk in acute stroke by fiberoptic endoscopy in critically ill patients. *Acute and critical care*.

https://pmc.ncbi.nlm.nih.gov/articles/PMC9475167/?utm_source=chatgpt.com

