N431 Care Plan # 2

Lakeview College of Nursing

Name: Ashley Bode

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/28/19	LR	81 y/o	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	Demerol nausea
Code Status	**Height**	**Weight**	
Full Code	5’7”	107.5 kg	

Medical History (5 Points)

Past Medical History: HTN, Diabetes Mellitus, Hyperlipidemia

Past Surgical History: No past surgical history

Family History: Father MI

Social History (tobacco/alcohol/drugs): former smoker, ½ pack a day for 30 years.

Assistive Devices: No assistive devices

Living Situation: Lives at home with his wife.

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): Expressive Aphasia

History of present Illness (10 points): Patient was brought to the Emergency department because of confusion, expressive aphasia, which started around noon on 10/27/19. Location of expressive aphasia originates from Broca's area in the brain which is responsible for language and comprehension. Patient was brought to the ED around 8 am on 10/28/19 and had only minor issues expressing language but improved as the day went on. Family stated that patient was unable to use a phone or TV remote and required assistance which is out of the ordinary for this patient. Family stated that patient was having difficulty verbalizing words. No facial droop, slurred speech or weakness was present. This patient had no

aggravating or relieving factors. The episode of aphasia lasted roughly 20 hours. Episode was not as severe as patient was able to talk and comprehend information.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Expressive Aphasia

Secondary Diagnosis (if applicable): CVA

Pathophysiology of the Disease, APA format (20 points):

A CVA occurs when there is an interruption of blood and oxygen to part of the brain. This occurs due to an obstruction in the blood vessels. When this happens a series of cellular metabolic events known as the ischemic cascade are activated. The ischemic cascade begins when the blood flow is decreased causing aerobic neurons in the brain to fail and switch to an anaerobic process (Hinkle, Cheever, & Brunner, 2018). This changes causes a buildup of lactic acid which changes the ph. This causes the neurons to fail which in turn depletes the electrolytes in the brain and the cells no longer function. Classic signs and symptoms of a CVA include severe headache that a patient may be described as the worst headache in their life, stiff neck, and loss of consciousness, vomiting and seizures (Linton, 2016). Other symptoms include sudden numbness or weakness in the face, arm, or leg typically on one side of the body, sudden confusion, trouble speaking or understanding, sudden trouble seeing in one or both eyes, sudden trouble walking, dizziness, loss of balance or coordination. Patients experiencing a CVA may present with a compromised airway causing loss of gag or cough reflex, altered respiratory status, cardiovascular status including changes in blood pressure, change in heart rate and rhythm and possible carotid bruit (Linton, 2016). The gold standard for diagnosing a patient with a CVA is a

non-contrast CT scan that should be performed within 25 min or less from entrance of ED (Hinkle, Cheever, & Brunner, 2018). Other diagnostic tests that could be ordered would be a 12 lead ECG, possible carotid ultrasound, CT angiography, CT perfusion, and MRI or Doppler studies. This patient presented as a CVA and underwent several diagnostic studies. These studies included a Chest X-ray, a CT without contrast, and an MRI with contrast. The findings consistent with areas acute or subacute infarction in the left cerebellum and right parietal lobe. Treatment for a CVA depends on the severity of the stroke. Treatment could include anticoagulation therapy or surgery to stop any severe bleeding (Linton, 2016). The treatment used on this patient included starting the patient on low dose Aspirin and Eliquis both used as anticoagulation agent. Patient presented at the ED with expressive aphasia. Family stated that he had a sudden onset of confusion and was unable to perform simple tasks such as using a phone and remote control. Family also stated that patient showed difficulty with vocalization and patient became frustrated. Patient has a history of hypertension and family history of MI (father). On examination patient showed no signs of difficulty talking and was able to answer all questions. Patient passed stroke protocol questionnaire. Patient vital signs on admission were pulse 85, BP 127/71, RR 18, Temp 97.8 F, O2 96 on room air. Patient vital signs at 3pm were pulse 93, BP 137/74, RR 18, Temp 97.6 F, O2 93 on room air. Patient will continue to be monitored.

Pathophysiology References (2) (APA):

Hinkle, J. L., Cheever, K. H., & Brunner, L. S. (2018). ***Brunner & Suddarths textbook of medical-surgical nursing*****. Philadelphia: Wolters Kluwer.**

Linton, A. D. (2016). *Introduction to medical-surgical nursing*. St. Louis, MO: Elsevier.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.40-5.80	4.61	NA	Normal
Hgb	13.0-16.5	12.8	NA	Normal
Hct	38.0-50.0	38.2	NA	Normal
Platelets	140-440	274	NA	Normal
WBC	4.00-12.00	9.30	NA	Normal
Neutrophils	40-68	65.4	NA	Normal
Lymphocytes	19.0-49.0	23.5	NA	Normal
Monocytes	3.0-13.0	8.2	NA	Normal
Eosinophils	0.0-8.0	2.2	NA	Normal
Bands	3-5	NA	NA	Normal

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	133-144	136	NA	Normal
K+	3.5-5.1	4.6	NA	Normal
Cl-	98-97	99	NA	The chloride is high because the patient is slightly dehydrated (Pagana & Pagana, 2014).
CO2	21-31	25	NA	Normal
Glucose	70-99	231	NA	The patient is diabetic (Pagana & Pagana, 2014).

BUN	**7-25**	**14**	**NA**	**Normal**
Creatinine	**0.50-1.20**	**1.07**	**NA**	**Normal**
Albumin	**3.5-5.7**	**3.8**	**NA**	**Normal**
Calcium	**8.6-10.3**	**9.0**	**NA**	**Normal**
Mag	**1.5-2.5**	**NA**	**NA**	**NA**
Phosphate	**2.5-4.5**	**NA**	**NA**	**NA**
Bilirubin	**0.2-0.8**	**0.4**	**NA**	**Normal**
Alk Phos	**34-104**	**68**	**NA**	**Normal**
AST	**10-40**	**NA**	**NA**	**NA**
ALT	**7-56**	**NA**	**NA**	**NA**
Amylase	**23-85**	**NA**	**NA**	**NA**
Lipase	**0-160**	**NA**	**NA**	**NA**
Lactic Acid	**0.5-1**	**NA**	**NA**	**NA**
Troponin	**0-0.4**	**NA**	**NA**	**NA**
CK-MB	**5-25**	**NA**	**NA**	**NA**
Total CK	**22-198**	**NA**	**NA**	**NA**

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**<1.1**	**NA**	**NA**	**NA**

PT	**11-13.5**	**NA**	**NA**	**NA**
PTT	**2-3**	**NA**	**NA**	**NA**
D-Dimer	**<0.50**	**NA**	**NA**	**NA**
BNP	**<450**	**NA**	**NA**	**NA**
HDL	**40-59**	**NA**	**NA**	**NA**
LDL	**<100**	**NA**	**NA**	**NA**
Cholesterol	**<200**	**NA**	**NA**	**NA**
Triglycerides	**<150**	**NA**	**NA**	**NA**
Hgb A1c	**4-5.6**	**NA**	**NA**	**NA**
TSH	**0.4-4.0**	**NA**	**NA**	**NA**

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**light yellow**	**NA**	**NA**	**NA**
pH	**4.5-8.0 6.0 Average value**	**NA**	**NA**	**NA**
Specific Gravity	**1.002-1.030**	**NA**	**NA**	**NA**
Glucose	**Not present**	**NA**	**NA**	**NA**
Protein	**0-20**	**NA**	**NA**	**NA**
Ketones	**Not present**	**NA**	**NA**	**NA**
WBC	**Not present**	**Na**	**NA**	**NA**
RBC	**Not present**	**NA**	**NA**	**NA**
Leukoesterase	**Not present**	**NA**	**NA**	**NA**

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	NA	NA	NA
PaO2	80-100	NA	NA	NA
PaCO2	35-45	NA	NA	NA
HCO3	22-26	NA	NA	NA
SaO2	95-100	98	Na	NA

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	No growth	NA	NA	NA
Blood Culture	No growth	NA	NA	NA
Sputum Culture	No infection	NA	NA	NA
Stool Culture	Negative	NA	NA	NA

Lab Correlations Reference (APA):

Pagana, K. D., & Pagana, T. J. (2014). *Mosby's manual of diagnostic and laboratory tests*.

St. Louis, MO: Elsevier Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

XR Chest single view: No acute cardiopulmonary abnormality, No consolidation, pneumothorax or effusion, Heart size and pulmonary vascularity within normal limits

CT head and brain without contrast: small-moderate low-density area in the right anterior parietal region extending to cortical surface, acute or subacute infarction is not excluded.

MRI of Brain with contrast: Findings consistent with areas acute or subacute infarction in the left cerebellum and right parietal lobe.

Diagnostic Test Correlation (5 points): Chest X-ray, CT head and brain, and MRI performed to rule out hemorrhaging, or post damage from CVA. Related to CC of expressive aphasia. Pt age, family history of MI, and hx of smoking put pt at higher risk for CVA

Diagnostic Test Reference (APA):

Pagana, K. D., & Pagana, T. J. (2014). ***Mosby's manual of diagnostic and laboratory tests*****. St. Louis, MO: Elsevier Mosby.**

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**(Allegra) fexofenadine**	**(Glucotrol) Glipizide**	**(Januvia) Sitagliptin**	**(Hyzaar) Hydrochlorothiazide**	
Dose	**180 mg**	**10 mg**	**100mg**	**50-12.5 mg**	
Frequency	**Once daily**	**Once daily**	**Once daily**	**Once daily**	
Route	**PO**	**PO**	**PO**	**PO**	

Classification	**Histamine antagonist, 2nd generation**	**antidiabetic**	**antidiabetic**	**antihypertensive**	
Mechanism of Action	**Blocks pharmacologic effects of histamine**	**Causes B cells in the pancreas to release insulin.**	**slow inactivation of incretin hormones, improves glucose homeostasis**	**Acts on the distal tubule in the kidney, increasing excretion of sodium, water, chloride and potassium.**	
Reason Client Taking	**seasonal allergies**	**Diabetes**	**Diabetes**	**HTN**	
Contraindications (2)	**narrow angle glaucoma, urinary retention**	**Hypersensitivity to sulfa drugs, type 1 diabetes**	**angioedema diabetic ketoacidosis**	**Hypersensitivity to sulfa or thiazides. Renal decomposition.**	
Side Effects/Adverse Reactions (2)	**drowsiness, headache**	**Headache, dizziness, weakness. hypoglycemia**	**Headache, nausea, vomiting**	**orthostatic hypotension, hypokalemia**	
Nursing Considerations (2)	**Assess for allergies such as itchy, runny, watery eyes, congested nose before and after treatment.** **Assess respiratory**	**Assess for hypoglycemia/hyperglycemia (sweating, weakness, dizziness, anxiety, tremors, and hunger).** **Blood dyscrasias**	**monitor for hypoglycemic reactions (sweating, weakness, dizziness, anxiety, tremors, hunger)** **Monitor for serious skin reactions**	**Monitor glucose in urine if patient is diabetic.** **Monitor electrolytes (K+, NA+, CA, Mag)**	

	status: rate, rhythm, increase in bronchial secretions, wheezing and chest tightness.		**(swelling of face, mouth, lips, dyspnea, wheezing)**		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Renal labs (BUN, creatinine) Respiratory status,**	**CBC, A1C, glucose level**	**CBC. AST, LDH, Bun, Creatinine, A1C, blood glucose levels**	**K+, NA+, Ca, Mag, blood glucose, BUN, ABGS, CBC, Creatinine**	
Client Teaching needs (2)	**Take 1 to 2 hours before meals to increase absorption, Do not take with apple, orange or grapefruit juice.**	**Teach pt the importance of medication compliance and not to stop medication abruptly. Watch for symptoms of cholestatic jaundice (dark urine, pruritus, yellow sclera) notify dr immediately**	**Teach patient to monitor blood glucose levels daily.** **Advise patient to avoid OTC medications.**	**Teach patient to rise slowly from sitting or reclining position.** **Take medication early in the morning to prevent nocturia.**	

Hospital Medications (5 required)

Brand/Generic	**(Lipitor) atorvastatin**	**(Lovenox) enoxaparin**	**Aspirin**	**(Eliquis) apixaban**	**(Tylenol) acetaminophen**
Dose	**40mg**	**40 mg**	**81 mg**	**5 mg**	**650 mg**
Frequency	**Once Daily**	**Once daily**	**Once daily**	**Twice daily**	**PRN**
Route	**PO**	**Sub Q**	**PO**	**PO**	**PO**
Classification	**Antilipidemic**	**Anticoagulant**	**Nonopioid analgesic**	**anticoagulant**	**Nonopioid analgesic**
Mechanism of Action	**inhibits HMG-CoA reductase enzyme to reduce cholesterol synthesis**	**Binds to antithrombin III inactivating factors Xa/XIIa**	**decrease platelet aggregation**	**decreases blood clot formation**	**blocks pain impulses**
Reason Client Taking	**Hyperlipidemia**	**to prevent blood clots**	**Prophylactic blood thinner**	**to prevent blood clots**	**As needed for mild to moderate pain**
Contraindications (2)	**Hypersensitivity, active liver disease**	**Hypersensitivity to enoxaparin, heparin or pork.** **active major bleeding**	**GI Bleeding or bleeding disorders, vitamin K deficiency**	**Active bleeding** **Severe hepatic impairment**	**Liver impairment, renal impairment.**
Side Effects/Adverse Reactions (2)	**Abdominal cramps, constipation, diarrhea**	**Thrombocytopenia, hemorrhage from any site.**	**GI bleeding, dysrhythmias**	**Bleeding** **Hypersensitivity and anaphylaxis**	**Hepatotoxicity, nausea, vomiting, abdominal pain.**

Nursing Considerations (2)	**Assess hypercholesterolemia (nutrition, fat, protein, carbs)** **Monitor bowel patterns (diarrhea may be severe)**	**Asses for bleeding, petechiae, ecchymosis.** **Monitor blood studies (CBC, HCT, coagulation studies and occult stool).**	**Monitor liver function.** **Monitor renal function.**	**Assess for signs of stroke, DVT, PE** **Monitor for signs of toxicity as there is not antidote**	**Monitor liver function tests (AST/ALT).** **Monitor renal studies (BUN, Creatinine)**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**ALT, AST, BUN, Creatinine, LDL and HDL levels.**	**AST/ALT, BUN, Creatinine, CBC, PTT, platelets.**	**ALT/AST, BUN, Creatinine, CBC, PT**	**PT, INR, CBC**	**CBC, BUN, Creatinine, ALT/AST**
Client Teaching needs (2)	**Advise patient to stay out of the sun, wear protective clothing and wear sunscreen.** **Decrease high fat foods, smoking, alcohol, and exercise regularly.**	**Do not take over the counter medications unless cleared with dr.** **Advise patients to report any signs of bleeding immediately.**	**Teach patient not to exceed the recommended dose.** **Teach patient to take with 8 oz. of water.**	**Teach patient that they will bruise and bleed more easily.** **Instruct patient not to take OTC medications as there could be an interaction.**	**Do not exceed the recommended dose could lead to acute toxicity.** **Avoid alcohol and OTC medications.**

Medications Reference (APA):

Skidmore-Roth, L. (2017). ***Mosby's drug guide for nursing students*****. St. Louis, MO: Elsevier.**

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alert** **Orientation: O*4** **Distress: Not in distress** **Overall appearance: Normal**	**Pt was alert and O*4, no acute distress noted, overall appearance well-groomed and resting comfortably, opens eyes spontaneously, arouses to voice or touch, follows commands, speech spontaneous and logical, purposeful motor response, behavior appropriate to the situation.**
INTEGUMENTARY (2 points): **Skin color: WDL** **Character: WDL** **Temperature: WDL** **Turgor: WDL** **Rashes: None** **Bruises: None** **Wounds: None** **Braden Score: 23** **Drains present: Y☐ N ☐** **Type:**	**Pt. skin warm dry and pink, skin turgor elastic, no rashes, bruises or wounds, Braden score of 23, no drains present.**
HEENT (1 point): **Head/Neck: WDL** **Ears: WDL** **Eyes: WDL** **Nose: WDL** **Teeth: WDL**	**Head/Face/eyes and nose symmetrical at rest and with movement, no edema, redness or discoloration, no external drainage, nares patent, lips/oral mucosa pink, moist and intact, swallows without difficulty, no expressed or observed changes in hearing or vision, dentition clean and normal , Sclera clear and white, auricles of ears clean warm pink and no lesions noted.**
CARDIOVASCULAR (2 points): **Heart sounds: WDL** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):Normal Sinus** **Peripheral Pulses:WDL** **Capillary refill:WDL** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema: NA**	**Regular rhythm (Normal Sinus), S1 and S2 heard not murmurs or gallops or rubs noted, Peripheral pulses heard bilaterally, Cap refill less than 3 sec, no neck vein distention, no edema**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Regular depth and pattern unlabored, expansion symmetrical, breath sounds clear and equal bilaterally, no cough present, no use of accessory muscle**

GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	**Abdomen soft and not distended, bowel sounds audible, normoactive in 4 quadrants, no reported or observed nausea, vomiting, diarrhea or constipation. Pt eats regular diet at home and is currently on a diabetic diet while in hospital, height is 5'7" and weighs 107.5kg, Last bowel movement 10/28/19, No pain on palpation or masses felt, pt abdomen not distended, no incisions, scars, drains or wounds, pt does not have an ostomy, NG tube, or feeding tubes.**
GENITOURINARY (2 Points): **Color: WDL** **Character: WDL** **Quantity of urine: WDL** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**No reported or observed difficulties with voiding, urine reported or observed as clear, yellow and without foul odor, no abnormalities of genitalia no lesions or sores noted, Pt not on dialysis and has no catheter.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score: 3** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Capillary refill less than 3 sec, extremities warm with 2+ pulses throughout, no discoloration or edema, no reported numbness, tingling or tenderness, full range of motion, no supportive devices used, strength equal bilaterally throughout, no assistance with ADLs, not a fall risk, pt has a fall risk score of 3, pt active and mobile, up and independent, does not need assistance with equipment, does not need support to stand and walk but requested healthcare worker be in room when getting up.**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐**	**Pt moves all extremities well without difficulty, PERLA, strength equal in both arms and legs, oriented*4, mental status alert and oriented,**

Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐ **Orientation: WDL** **Mental Status:WDL** **Speech: WDL** **Sensory: WDL** **LOC: WDL**	**speech clear and not slurred, sensory functions intact and LOC alert and keenly responsive.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Pt reported that he has coping methods that he uses to deal with stress in his life. Pt has high developmental level. Pt stated he is not religious. Pt has a great support system. He lives with his wife at home and is cared for by both her and their daughter.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1234	85	127/71	18	97.8 F	96 Rm Air
0300	93	137/74	18	97.6 F	93 Rm Air

Vital Sign Trends: Vital signs remained stable throughout clinical shift. Admission vitals were pulse 85, BP 127/71, RR 18, Temp 97.8 F, O2 98 on room air. 3pm vitals were pulse 93, BP 137/74, RR 18, Temp 97.6 F, O2 93 on room air. Patient has a history of diabetes and HTN. Patient taking 2 antidiabetic medications and 1 hypertensive medication.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1235	0-10 pt denies pain	None pt denies pain	None pt denies pain	None pt denies pain	None pt denies pain
0300	0-10 pt denies pain	None pt denies pain	None pt denies pain	None pt denies pain	None pt denies pain

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV: metacarpal vein right hand** **Date on IV:10/28/19** **Patency of IV: IV patent** **Signs of erythema, drainage, etc.: No signs of erythema, drainage, or swelling** **IV dressing assessment: Dressing dry and intact**	**Pt has 20 IV in right hand, currently not on an IV fluids, covers on all caps on lumens.**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
16 oz. of water during clinical shift	**60 mL recorded during clinical shift**

Nursing Care

Summary of Care (2 points)

Overview of care: Greeted patient and assisted nurse with admission, Check on patient throughout the day, took part in the bathroom (no assistance needed just wanted someone to be in the room when walking), pt went to the bathroom on own and assisted with getting back and bed and making sure comfortable. Performed 3pm vitals and made sure call light was in reach.

Procedures/testing done: Pt did not have any procedures or tests done during clinical shift.

Complaints/Issues: Patient had no complaints or issues was not happy about having to stay in the hospital.

Vital signs (stable/unstable): Vital signs remained stable throughout shift. Admission vitals 97.8 F, 96% O2 room air, BP 127/71, RR 18, and Pulse 85. Vitals 3pm 97.6 F, 93% room air, BP 137/74, RR 18, Pulse 93. Nurse notified of vital signs before charting.

Tolerating diet, activity, etc.: Patient is on a diabetic diet and activity as tolerated. Patient had not issues with mobility and is able to walk and sit in the chair on own.

Physician notifications: No Physician notifications at time of clinical shift. Patient was recently admitted.

Future plans for patient: Pt will be kept overnight for further investigation into stroke activity.

Discharge planning (2 points)

Discharge location: Patient will be discharged to home.

Home health needs (if applicable): Patient may need consultation from care management on cost of new anticoagulation medication.

Equipment needs (if applicable): Patient will need no equipment needed at home.

Follow up plan: Patient will need to follow up with primary and possible follow up with neurology.

Education needs: Patient given handout education on new anticoagulant medication and will need to know safety precautions and signs and symptoms to watch for and when to seek medical help.

Nursing Diagnosis (15 points)
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	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Acute Confusion	**Pt presented to the ED with**	**1. Monitor neuro status every 2**	**Pt and family responded well to this intervention.**

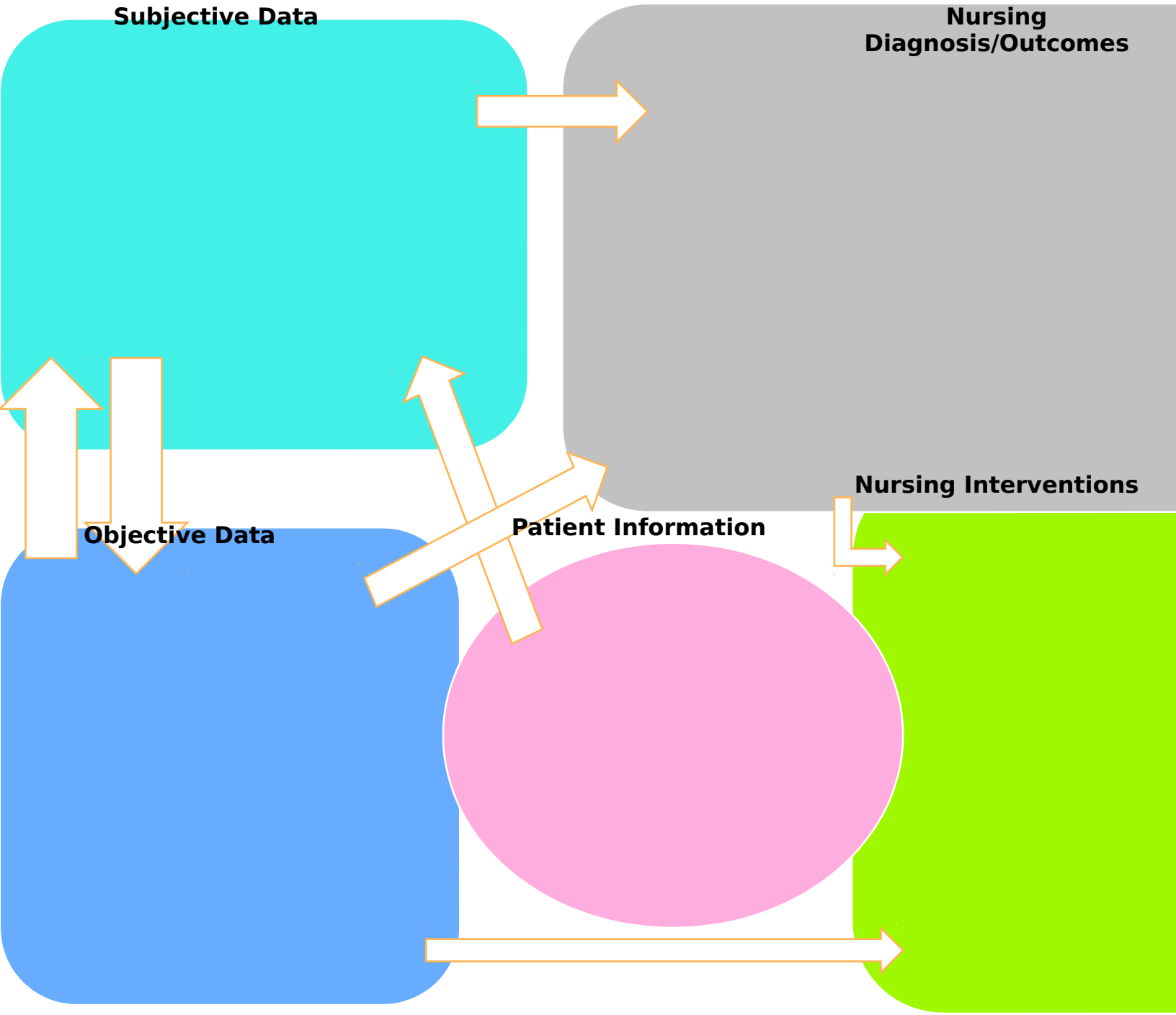
related to CVA aeb sudden onset of pt not being able to use phone or remote control	**suspected CVA. Pt family stated he could not remember how to use the remote control or phone and required help**	**hours.** **2. Enlist the aid of family to help orient patient.**	**Pt was monitored every 15 min upon admission and 1 then 2 hour increments after that. Pt vitals and neuro remained stable throughout shift. This goal was met during clinical shift.** **Family was onsite to help assist patient and provide information about the event that led to admission.**
2. Impaired memory related to neurological disturbance AEB pt statement "I cannot remember what happened".	**Pt had sudden onset of confusion and by the time medical help was sought pt could not remember what initially had happened.**	**1. Observe and assess patient thought process throughout shift.** **2. Teach patient ways to cope with memory loss.**	**Pt was observed every hour during clinical shift. Pt remained stable and showed no signs of neuro defect. Pt responded well to observation.** **Pt was assessed on memory loss and talked about coping strategies to deal with any memory loss from possible CVA. Pt responded well and asked appropriate questions.**
3. Risk for injury related to CVA aeb pt being shaky on feet	**Pt is able to walk unassisted but stated at times he feels shaky and unsteady on his feet**	**1. Help patient and family identify situations and hazards that can cause accidents.** **2 Improve environmental safety by observing pt and suggesting changes to promote safety.**	**Pt instructed on hazards that can cause accidents. Pt verbally understood changes to make to maintain safety and prevent injury. Family understood safety concerns.** **Talked to pt and family about safety precautions and any hazards in the home setting that need changed when returning**

			home.
4. Impaired verbal communication related to decreased circulation to the brain aeb family statement of slurred speech	**At the onset of symptoms pt family reported slurred speech and difficulty speaking. On arrival at the ED pt denied slurred speech.**	**1. Monitor and record patient's speech pattern and level of orientation.** **2. Speak slowly and in a normal tone so patient can comprehend better.**	**Pt was assessed using stroke protocol and speech pattern and level of orientation showed nothing abnormal. Goal met during clinical shift.** **Pt is an elderly client and was spoken to slow and clear so pt could understand. Goal met during clinical shift.**
5. Impaired walking related to neuromuscular dysfunction aeb difficulty walking after suspected CVA.	**Pt had difficulty walking after onset of symptoms in suspected CVA**	**1. Monitor patient while ambulating to observe for changes.** **2. Make sure patient uses proper body mechanics when performing position changes.**	**Pt was monitored during times when pt had to get out of bed. Pt had steady gait and no observed difficulty walking. Goal met during clinical shift.** **Pt instructed to change positions slowly and use proper body mechanics. Pt agreed and was more aware when getting in and out of the bed and chair. Goal met during clinical shift.**

Other References (APA):

Lippincott Williams & Wilkins. (2013). ***Spark & Taylors: Nursing diagnosis reference manual*****. London.**

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Nursing Interventions
Objective Data
Patient Information