N431 Care Plan 3

Lakeview College of Nursing

Shayla Mitchell

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
3-17-2020	O.B.	60	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Truck Driver	Divorced	Sulfa Drugs - Rash and itchy/watery eyes
Code Status	**Height**	**Weight**	
Full Code	5'10	220 lbs.	

Medical History (5 Points)

Past Medical History: Hypertension, Hypercholesterolemia, Diabetes Mellitus Type II (uncontrolled), Obesity (BMI 31.6)

Past Surgical History: Colonoscopy - 2018

Family History: Mother – Diabetes, Father – MI s/p CABG, Brother – Obesity, Sister – Breast Cancer s/p mastectomy

Social History (tobacco/alcohol/drugs): Tobacco - 1 pack/day smoker for 40 years

Alcohol – patient denies use

Drugs – patient denies use

Assistive Devices: No assistive device use

Living Situation: Lives home alone when not on the road with current career as a truck driver

Education Level: GED, no other education noted

Admission Assessment

Chief Complaint (2 points): Acute right sided weakness and facial droop

History of present Illness (10 points): The patient is a 60-year-old male who presented to the Emergency Department via EMS for sudden onset right-sided weakness and facial dropping. The patient was admitted and immediately taken to CT which revealed no acute bleed. The patient was given 0.9mg of Tissue Plasminogen Activator (TPA) bolus, followed by a drip of 81mg/hr.

The patient showed noted improvement in right-sided weakness and facial droop. The patient was held in the ED for 24 hours due to limited ICU bed availability and is now being admitted to the neurological unit for further evaluation under the care of Dr. Farquad. A bedside swallow study was completed by J.S. and revealed no issues noted. A consistent-carbohydrate diet has been ordered. He does swallow pills with no issues noted.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Ischemic Stroke

Secondary Diagnosis (if applicable):.

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

Ischemic strokes result from an obstruction in cerebral blood flow by a thrombus or embolus. The arterial vessels most commonly involved in ischemic strokes include the internal carotid and middle cerebral arteries. A thrombus usually travels up the internal carotid artery into the middle cerebral arteries and becomes lodged, causing ischemia or swelling of the brain issue. Ischemia leads to cerebral infarction or death of tissue. The middle cerebral artery is the most common artery affected by stroke because is supplies the brain with more than 80% of its blood flow. A thrombus is the frequently the cause of an ischemic stroke. The thrombi commonly arises from arteriosclerotic plaque in a cerebral artery (Capriotti & Frizzell, 2016). The patient's plaque buildup was caused because of his past medical history including hypertension.

The signs and symptoms of ischemic stroke include neurological deficits and the neurons within the left or right hemisphere become injured and die. Clinical manifestations include slurred speech, loss of gag reflex, facial droop, hemiparesis (weakness of extremities on one side of the body), or hemiparalysis (complete loss of function on one side of the body), vision loss in

one or both eyes, and loss of sensation. Some patients may have disorientation, confusion, sleepiness, and aphasia (Hersh, 2018). My patient presented to the emergency department with right-sided weakness and facial droop that was fixed with administration of tissue plasminogen activator (TPA).

Concerning vital signs, a neurological and cardiovascular assessment should be performed. This includes auscultation of carotid arteries for bruits, blood pressure in both arms, and ophthalmoscopic examinations. The patient has hypertension which should be managed properly by medication. All other vital signs are within normal limits.

Early diagnostic and treatment of ischemic stroke are key to successful outcome. Diagnostic testing needs to include electrocardiogram, chest x-ray, blood work, and brain imaging studies. This testing should rule out other pathological processes with symptoms that could mimic stroke, such as hypoglycemia, hyperglycemia, vasculitis, migraine, seizure disorder, and tumor. The patient received an EKG, chest x-ray, and CT head without contrast.

Treatment of ischemic stroke focuses on intra-arterial thrombolysis, which dissolves the clot that is blocking blood flow and allows for reperfusion to occur. It is vital that this therapy be administered within 3 hours of symptoms onset. The patient was treated with TPA. Patients are also treated with aspirin or another antiplatelet aggregation during the acute phase of ischemic stroke. My patient is receiving Plavix.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*: F.A. Davis Company.

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Hersh, E. (2018, September 29). Ischemic Stroke: Symptoms, Treatment, Recovery, and More. Retrieved from https://www.healthline.com/health/stroke/cerebral-ischemia

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	4.5-5			
Hgb	11.3-15.2		15.3 High	The patient's Hgb could be elevated due to the body making too many RBC causing the blood to be thicker than usual leading to a clot and ischemic stroke (Kee, 2018).
Hct	33.2-45.3		47 High	The patient's Hit could be elevated due to the body making too many RBC causing the blood to be thicker than usual leading to a clot and ischemic stroke (Kee, 2018).
Platelets	149-393		143 Low	The patient's platelets could be elevated due to ischemic stroke causing blood to be thicker than usual leading to blood clots (Kee, 2018).
WBC	4-11.7		6.3	
Neutrophils	2.4-8.4			
Lymphocytes	11.8-45.9			
Monocytes	4.4-12			
Eosinophils	0-6.3			
Bands	0.1.0			

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-	135-145		139	
K+	3.5-5.1		3.6	
Cl-	98-107		106	
CO2	21-31			
Glucose	74-109		147 High	The patient's glucose is elevated due to his history of diabetes mellitus type II uncontrolled (Kee, 2018).
BUN	7-25		15	
Creatinine	0.5-0.9		0.9	
Albumin	3.5-5.2			
Calcium	8.6-10.3			
Mag	1.5-2.5			
Phosphate	35-105			
Bilirubin	0.3-1.0			
Alk Phos	20-140			
AST	0-32			
ALT	0-33			
Amylase	23-85			
Lipase	0-160			
Lactic Acid	0.5-1.0			

Troponin	0-.0.4			
CK-MB	3-5%			
Total CK	22-198			

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	0.86-1.14		1.03	
PT	11.9-15.0		11.3 High	The patient's PT could be elevated due to ischemic stroke causing blood to be thicker than usual leading to blood clots (Kee, 2018).
PTT	22.6-35.3		33.6	
D-Dimer	<0.50			
BNP	<100			
HDL	23-92			
LDL	<100			
Cholesterol	<130			
Triglycerides	0-149			
Hgb A1c	< = 6.4		9.4 High	The patient's Hgb A1C is elevated due to his history of diabetes mellitus type II uncontrolled (Kee, 2018).
TSH	0.45-5.33			

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 Admissio	Today's Value	Reason for Abnormal

		n		
Color & Clarity	Yellow/ Clear			
pH	4.5-8.0			
Specific Gravity	1.010-1.030			
Glucose	0 – 0.8			
Protein	0-20mg/dL			
Ketones	Negative			
WBC	Negative			
RBC	Negative			
Leukoesterase	Negative			

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			
PaO2	80-100			
PaCO2	35-45			
HCO3	22-28			
SaO2	95-100			

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	Negative			
Blood Culture	Negative			
Sputum Culture	Negative			

Stool Culture	Negative			

Lab Correlations Reference (APA):

Kee, J. L. F. (2018). *Laboratory and Diagnostic Tests with Nursing Implications*. Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest x-ray, CT head without contrast, and EKG

Diagnostic Test Correlation (5 points): A chest x-ray is a diagnostic procedure that visualizes the heart, lungs, blood vessels, airway, spine, and bones of the chest. A chest x-ray was ordered for my patient to rule out any other abnormalities or causes of injury. The results revealed no acute abnormalities and cardiac silhouette is within normal limits. A CT head without contrast is a diagnostic procedure used to diagnose brain bleeding, brain injury, or skull fractures. The patient received a CT head because he presented with facial drooping and that is a sign of neurological deficits or injury. The CT head will help identify any sources of injury. The CT results revealed no acute intracranial hemorrhage, mass, mass effect, or mid-line shift. The ventricles are symmetrical. There is no convincing evidence of an acute territorial infarction. An EKG is a test that measures the electrical activity of the heart. This was ordered because the patient has a history of hypertension. The EKG revealed ST without ectopy.

Diagnostic Test Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Prinivil/Lisinopril	Lipitor/Atorvastatin	Glucophage/Metformin	MiraLAX/Polyethylene glycol	Glyceryl Trinitrates/Nitroglycerin
Dose	10mg	20mg	250mg	17g	0.4mg
Frequency	BID	Daily	BID	Daily, PRN	Q5min, PRN
Route	PO	PO	PO	PO	SL
Classification	ACE Inhibitor	Lipid-Lowering Agents, Statins	Antidiabetics, Biguanides	Laxative, Osmotic	Nitrates, Angina
Mechanism of Action	ACE Inhibitors dilate arteries and veins by inhibiting the conversion of angiotensin I to angiotensin II and by inhibiting bradykinin metabolism; these actions result in preload and afterload reductions on the heart.	HMG- CoA reductase inhibitor; inhibits rate-limiting step in cholesterol biosynthesis by inhibiting HMG-CoA reductase.	Decreases hepatic glucose production; decreases GI glucose absorption; increases target cell insulin sensitivity.	Osmotic laxative causes water retention in stool, causing increase in stool frequency.	Nitrate enters vascular smooth muscle and converted to nitric oxide leading to activation of cGMP and vasodilation. Organic nitrate which causes systemic vasodilation, decreasing preload.
Reason Client Taking	The patient is taking this medication to treat hypertension.	The patient is taking this medication to control lipid levels.	The patient is taking this medication to reduce blood glucose levels due to his type two diabetes.	The patient is taking this medication as needed for constipation.	The patient is taking this medication as needed for chest pain.
Contraindications (2)	History of ACE inhibitor-induced angioedema, hereditary or idiopathic angioedema Hypersensitivity to lisinopril/other ACE inhibitors	Active liver disease or unexplained transaminase elevation Hypersensitivity to atorvastatin	CHF Diabetic Ketoacidosis with or without coma	Gastrointestinal obstruction Gastric retention	Acute MI Severe anemia
Side Effects/Adverse Reactions (2)	Dizziness Cough	Diarrhea Nasopharyngitis	Asthenia Diarrhea	Abdominal bloating Abdominal cramping	Headache Hypotension
Nursing Considerations (2)	Monitor for dehydration, which can lead to hypotension especially if patient experiences diarrhea or vomiting. Monitor patient's serum potassium level, as ordered because drugs that inhibit the renin-angiotensin system such as lisinopril can cause hyperkalemia.	Monitor diabetic patient's blood glucose levels because atorvastatin therapy can affect blood glucose control. Expect to measure lipid levels 2 to 4 weeks after therapy starts until lipid levels are within desired range.	Give metformin tablets with food, which decreases and slightly delays absorption, thus reducing risk of adverse GI reactions. Assess for hyperglycemia and the need for insulin during times of increased stress, such as infection and surgery.	Dissolve medication in 8oz of water or juice. Assess client for abdominal distention.	Plan a nitroglycerin-free period of about 10 hours each day, as prescribed, to maintain therapeutic effects and avoid tolerance. Monitor frequently heart and breath sounds, level of consciousness, fluid intake and output, and pulmonary artery wedge pressure, if possible.
Key Nursing Assessment(s)/Lab(s) Prior to	Monitor patient's serum creatinine, as ordered because changes in renal function can occur with lisinopril use.	Expect liver function test to be performed before atorvastatin therapy begins and then after.	Monitor patient's blood glucose level to evaluate drug effectiveness.	Monitor for the presence of bowel sounds and usual pattern of bowel function.	Monitor vital signs before every administration (heart and breath sounds).

Administration					
Client Teaching needs (2)	Advise patient to take this medication at the same time daily. Inform patient that persistent, nonproductive cough may develop during lisinopril therapy.	Advise patients with diabetes to monitor blood glucose levels closely. Tell patient to take drug at the same time each day to maintain its effect.	Emphasize importance of checking blood glucose level regularly, controlling weight, exercising regularly, and following prescribed diet. Caution patient to avoid alcohol, which can increase the risk of hypoglycemia and lactic acid.	Instruct client to hydrate adequately with water and/or clear liquids before, during, and after use Inform client that 2-4 days may be required to produce a bowel movement.	Patient should administer sublingually 3 doses that are 5 minutes apart. The patient can take sublingual medication with a sip of water.

Hospital Medications (5 required)

Brand/Generic	Plavix/Clopidogrel	Lopressor/Metoprolol	Zofran/Ondansetron	Tylenol/Acetaminophen	MS Contin /Morphine
Dose	75mg	50mg	4mg	650mg	1mg
Frequency	Daily	BID	Q6hr, PRN	Q6hr, PRN	Q2hr, PRN
Route	PO	PO	ODT	PO	IV
Classification	Antiplatelet Agent	Beta Blocker, Beta 1 Selective	Antiemetics	Analgesics	Opioid Analgesic
Mechanism of Action	Inhibitor of adenosine diphosphate induced pathway of platelet aggregation.	Blocks response to beta-adrenergic stimulation; cardio selective for beta1 receptors at low doses, with little or no effect on beta2 receptors.	Binds to 5-HT3 receptors both in periphery and in CNS, with primary effects in GI tract.	Inhibits prostaglandin synthesis in CNS to block pain impulses.	Narcotic agonist-analgesic of opiate receptors; inhibits ascending pain pathways, thus altering response to pain; produces analgesia, respiratory depression and sedation; suppresses cough by acting centrally in medulla.
Reason Client Taking	The patient is taking this medication to reduce thrombotic events such as MI and stroke.	The patient is taking this medication to manage hypertension.	The patient is taking this medication as needed for nausea.	The patient is taking this medication as needed for pain/fever.	The patient is taking as needed for severe pain.
Contraindications (2)	Peptic ulcer bleed Intracranial hemorrhage	Hypertension Myocardial infarction	Hepatic impairment Hypersensitivity	Hypersensitivity Severe active liver disease	Paralytic ileus Respiratory depression
Side Effects/Adverse Reactions (2)	Upper respiratory tract infection Chest pain	Dizziness Headache	Headache Fatigue	Angioedema Disorientation	Pruritis Urinary retention
Nursing Considerations (2)	Expect to give aspirin with clopidogrel in patient with acute coronary syndrome. Monitor patient who takes aspirin closely because risk of bleeding is increased.	Check for poor glucose control in patient with diabetes mellitus. Expect to taper the dosage over 1 to 2 weeks when drug is discontinued; stopping abruptly can cause MI.	Know that if hypokalemia or hypomagnesemia is present, these electrolyte imbalances should be corrected before ondansetron is administered. Monitor patient closely for serotonin syndrome, which may include agitation, chills, confusion,	Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment. Before and during long-term therapy liver function test results, including AST, ALT,	Monitor for signs of sedation and respiratory depression, especially when initiating therapy. Morphine may reduce the respiratory drive. Ensure that when giving morphine that opioid antagonist and

			diaphoresis, diarrhea, and fever.	bilirubin, and creatinine levels.	equipment for oxygen delivery and respiration are available.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain blood cell count, as ordered, whenever signs and symptoms suggest a hematologic problem.	Assess ECG of patients who take this medication because they may be at risk for AV block.	Monitor the patient's EKG, as ordered, and especially in patients with bradyarrthymias, congestive heart failure, or hypomagnesemia.	Monitor renal function in patient on long-term therapy.	Monitor patient's respiratory rate prior to administration as morphine can cause respiratory depression.
Client Teaching needs (2)	Caution patient that bleeding may continue longer than usual. Instruct him to report unusual bleeding or bruising. Instruct patient not to discontinue this medication abruptly or without first consulting the provider.	Instruct client to take this medication with food at the same time every day. Advise patient to notify provider if heart rate falls below 60 bpm or is significantly lower than usual.	Instruct patient to place this medication on the tongue immediately after opening package and let it dissolve on his tongue before swallowing. Advise patient to seek immediate medical attention if patient experiences persistent, severe, unusual, or worsening symptoms.	Teach patient to recognize signs of hepatoxicity, such as bleeding, easy bruising, and malaise. Tell patient that tablets may be crushed or swallowed whole.	Tell patient to change position slowly to minimize the orthostatic hypotension. Instruct patient to notify provider about worsening or breakthrough pain.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). 2019 *Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is A/O x4. He is oriented to person, place, time, and president. The patient appears to not be in any distress at this time. But, does report mild weakness on the right side. The patient is cooperative and looks stated age.
INTEGUMENTARY (2 points):	Skin is pink, warm, and dry and appropriate for

Skin color: **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	ethnicity. The patient's temperature ranged between 36.9 and 37.0˚C during shift. Skin turgor was assessed on arms bilaterally and were both less than 3 seconds. No rashes, bruises, or wounds are present. The Braden score was not given; however, because the patient is 60-years-old and had an ischemic stroke, I would say he is a skin risk. No drains are present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The head is normocephalic, with no visible deformities or abnormalities. No facial droop noted. Speech is normal. Ears are normal and symmetric to face. PERLA is present with no visual disturbances. The nose is normal and symmetric to face. Teeth are normal. Lips, mucosa, and tongue all normal. .
CARDIOVASCULAR (2 points): **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:**	Regular rate and rhythm with S1 and S2 present. No murmurs gallops or rubs present upon auscultation at aortic, pulmonary, tricuspid, and mitral valve. Peripheral pedal pulses are 2+ bilaterally. Radial pulses are 2+ bilaterally. Capillary refill is less than 3 seconds on both hands. No chest tenderness or deformities. No neck vein distention or edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient did not have accessory muscle use. Right and left lungs are clear upon auscultation anterior and posterior—no adventitious breath sounds.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:**	The patient is on a consistent carbohydrate at home and inpatient. Height is 5 feet, 10 inches, and weight is 100 kg. Bowel sounds are present and active in all four quadrants. The abdomen is soft and non-tender upon palpitation in all four quadrants. No masses, distention, incisions, scars, drains, or wounds. The patient has no risk for aspiration. The patient's last bowel movement is today.

Wounds: **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine is clear and yellow. The patient is voiding ad-lib. The patient urinated twice during shift. Genitals look normal with no abnormalities.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Neurovascular status is normal. The patient has a bilateral, equal range of motion in all four extremities. The patient is a fall risk. The patient is independent and up ad-lib. The fall score is not known; however, the patient is a 60-year-old admitted for ischemic stroke, so I would say he is a fall risk: no joint abnormalities, cyanosis, or edema.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient is A/O x4. The patient can move all extremities equally and bilaterally. No sensory deficits. No hearing-aid or glasses. No altered mental status.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home**	The patient lives at home alone when he is not on the road with his current job as a truck driver. I did not ask the patient what religion means to him. No developmental delayed noted.

environment, family structure, and available family support):	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	76 bpm	163/76 mm/ Hg	16/min	37.0˚C	98% Room air
1100	69 bpm	124/63 Mm/Hg	18/min	36.9˚C	98% Room air

Vital Sign Trends:

he recommended blood pressure is less than 120/80. The patient's blood pressure is high due to his medical history of hypertension. The patient is receiving metoprolol for management. His other vitals are all within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric pain scale	Generalized head pain	4/10	Generalized	Tylenol administered
1100	Numeric pain scale	Generalized head pain	1/10	Generalized	No intervention at this time

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	IV Saline Locked 18-gauge needle Left Antecubital 3-17-2020 Patent No phlebitis, infiltration, erythema, or drainage present Transparent dressing – Dry, intact, and

	flushes easily

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
720 mL 600 ml water with breakfast 120 ml Sugar-free orange juice with breakfast	800 ml Urine voided in 4 hr. Stool x1

Nursing Care

Summary of Care (2 points)

Overview of care: Today, I took 0700 and 1100 vital signs on the patient. I also administered the patients scheduled morning medications and a PRN Tylenol for his pain level. The patient is has uncontrolled diabetes and hypertension, so I monitored him closely for any significant changes. None were noted. The patient is most likely on telemetry to monitor for any EKG changes, and I would have monitored that.

Procedures/testing done: A chest x-ray was performed to rule out any other abnormalities due to the patient's diagnosis of ischemic stroke. The patient also had an EKG performed to monitor for any changes due to his hypertension. The results were ST elevation without ectopy. A CT head without contrast was also performed to rule out any neurological deficits. No abnormalities noted.

Complaints/Issues: The patient complains of mild right-sided weakness. He is being monitored closely.

Vital signs (stable/unstable): The recommended blood pressure is less than 120/80. The patient's blood pressure is high due to his medical history of hypertension. The patient is receiving metoprolol for management. His other vitals are all within normal limits.

Tolerating diet, activity, etc.: The patient is on a low-carbohydrate diet and did eat breakfast this morning. This diet is new to the patient and he will need time and education about adjustment.

Physician notifications: Notify the physician of any abnormal changes on EKG.

Future plans for patient: The patient is being referred to PT/OT for continued strengthening of his right side. He is to make an appointment 1 week from his discharge date with the neurologist.

Discharge Planning (2 points)

Discharge location: Home with new medication orders including metoprolol 50mg BID, Clopidogrel 75mg PO daily, and an increase in metformin to 500mg daily.

Home health needs (if applicable):

Equipment needs (if applicable)

Follow up plan: Patient will follow up with his PCP in 6 weeks for a check of his A1C.

Education needs: The patient will need education in regard to maintaining a low-carbohydrate diet. The patient will also need education in regard to maintaining medication adherence of all new and previously prescribed medications.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

1. Impaired tissue perfusion related to interruption of arterial blood flow as evidence by weakness of right side.	Tissue perfusion is impaired by ischemic stroke due to the obstruction in the arterial artery.	**1.**Monitor for rapid changes or continued shifts in mental status. 2.Monitor blood pressure for orthostatic changes.	The patient was very cooperative in reporting any changing signs in his condition. The patient reported weakness subsiding after TPA administration.
2. Impaired physical mobility related to hemiparesis as evidence by patient self-report of right-sided weakness.	The patient is a fall risk because of the hemiparesis which could lead to falls or other injuries.	**1.** Turn and position the patient every 2 hours or as needed to optimize circulation to all tissues. **2.**Assess the strength to perform range of motion to affected side.	The patient understands how weakness on the right side could lead to impaired physical mobility. The patient has orders to attend physical and occupational therapy 1 week following discharge from hospital.
3. Risk for impaired swallowing related to ischemic stroke as evidence by facial drooping upon admission.	The patient presented to the emergency room with facial droop which could lead to impaired swallowing.	**1.** Maintain accurate intake and output record. **2** Have suction equipment available at the bedside, especially during early feeding efforts.	Ideally, the patient would have received a bedside swallow test while being admitted. If this were the case, the patient would have been cooperative and understand the risk associated with impaired swallowing such as eating difficulties and risk for aspiration.
4. Risk for injury related to ischemic stroke as evidence by mild right-sided weakness.	The patient is a fall risk due to right-sided weakness which could lead to injury.	**1.**Monitor the environment for safety hazards and remove unsafe items. **2.**Assess type and degree of hemisphere injury the patient exhibits.	The patient follows all fall risk precautions such as keeping bed in lowest position, wearing nonskid socks, and ringing call light when needed assistance getting out of bed or chair.

Other References (APA):

Gulanick, M., & Myers, J. L. (2017). *Nursing Care Plans: Diagnoses, Interventions, & Outcomes*. Elsevier.

Concept Map (20 Points):

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Subjective Data

Patient reports mild right-sided weakness
Patient reports pain 4/10 at 0700

Nursing Diagnosis/Outcomes

Impaired tissue perfusion related to interruption of arterial blood flow as evidence by weakness of right side.
By discharge, the patient will not have any tissue perfusion problems because the medication will continue to work.
Impaired physical mobility related to hemiparesis as evidence by patient self-report of right-sided weakness.
By discharge, the patient will be free of all possible injury which could result from impaired mobility.
Risk for impaired swallowing related to ischemic stroke as evidence by facial drooping upon admission.
By discharge, the patient will be able to swallow without difficulty and eat without impairment.
Risk for injury related to ischemic stroke as evidence by mild right-sided weakness.
By discharge, the patient will remain free of all possible injury such as falls.

Objective Data

0700 vital signs:
BP 163/76 mm/hg
HR 76 bpm
R 16/min
O2 98%
1100 vital signs:
BP 124/63 mm/hg
HR 69 bpm
R 18/min
O2 97%
Chest X-ray = no acute abnormalities
EKG = ST elevation without ectopy
CT Head = no acute abnormalities
Abnormal labs = Hgb, Hct, Platelets, PT, Glucose, Hgb A1C

Patient Information

Patient Initials: OB
60-years-old male
Admitted: 3-17-20
Full Code
Allergies: Sulfa Drugs -itching and rash
Height: 5ft 10in
Weight: 100kg

Nursing Interventions

Monitor for rapid changes or continued shifts in mental status
Monitor blood pressure for orthostatic changes.
Turn and position the patient every 2 hours or as needed to optimize circulation to all tissues.
Assess the strength to perform range of motion to affected side.
Maintain accurate intake and output record.
Have suction equipment available at the bedside, especially during early feeding efforts.
Monitor the environment for safety hazards and remove unsafe items.
Assess type and degree of hemisphere injury the patient exhibits.

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