N431 Care Plan #1

Lakeview College of Nursing

Ana Punsalan

Demographics (3 points)

Date of Admission 6/29/2020	**Patient Initials** D.J.	**Age** 71	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Veteran	**Marital Status** Single	**Allergies** Strawberry Extract
Code Status Full	**Height** 5'9"	**Weight** 126 lbs.	

Medical History (5 Points)

Past Medical History: Alcohol abuse, Chronic back pain, COPD, Extrapyramidal Syndrome, Gynecomastia, Hyperlipidemia, Hyperopia, Keratosis, Lung mass, Mandibular fracture, Neuroleptic-induced tardive dyskinesia, Schizoaffective disorder, Scoliosis, Squamous cell carcinoma and verruca vulgaris

Past Surgical History: There is no past surgical history on file due to patient being a poor historian.

Family History: There is no family history on file because the patient is a poor historian.

Social History (tobacco/alcohol/drugs): D.J. reports that has been smoking. He does not use smokeless tobacco. He reports previous alcohol use and no drug use.

Assistive Devices: Wheelchair & a thoracic walker

Living Situation: D.J. lives by himself at home and his brother visits him throughout the week.

Education Level: High School

Admission Assessment

Chief Complaint (2 points): Possible facial droop.

History of present Illness (10 points): D.J. is a 71-year-old Caucasian male. He presents to the hospital with complaints of possible facial droop. D.J. is a poor historian, so there is no history on file. The patient's brother stated that D.J. lives alone and has been battling schizophrenia over

the years, and he is on antipsychotics. His brother noted that the patient has some speech slurring, so he has been brought to the V.A. The V.A. brought D.J. to the hospital. Upon arrival, the patient appears to have a slight facial droop noted, uncoordinated balance, an altered level of consciousness, and confusion. His pulse and B.P. are high. A C.T. scan was done and was negative for intracranial abnormalities. He is currently taking aspirin to help reduce the risk of recurrent ischemic attacks and Norvasc to control his B.P.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): TIA (transient ischemic attack)

Secondary Diagnosis (if applicable): N/A

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

Transient Ischemic Attack

A transient ischemic attack (TIA) is also generally known as a mini-stroke. It takes place when a section of the brain undergoes a short-term lack of blood flow. A TIA is a disturbance of cerebral circulation with neurological deficiencies. A TIA creates stroke-like symptoms that last at least twenty-four hours and does not cause permanent damage. The clot that made the ischemia is dissolved naturally by the body, returning circulation (Capriotti & Frizzell, 2016).

According to the V.A., D.J. has a possible facial droop. D.J. cannot walk forward and back on his own and needs a thoracic walker or wheelchair for mobilization. He appears to have slurred speech that makes it difficult to comprehend what he is saying. He also has an altered level of consciousness and confusion. A TIA's signs and symptoms include weakness/numbness on one side of the face or body, uncoordinated balance, speech disorder, an altered conscious level, and confusion (Belliveau, 2019).

On the day D.J. is admitted to the hospital, his pulse rate and blood pressure were high. His pulse rate was 128, and his blood pressure was 164/113. One of the risk factors that can lead to stroke is having high blood pressure (Mayo Clinic, 2020). D.J.'s glucose level is 133, which is higher than the expected range. Uncontrolled blood sugar levels increase the chances of getting a stroke (Fletcher, 2019).

Diagnostic testing to help identify ischemia include a C.T. scan, an MRI, an electrocardiogram, and a carotid artery C.T. scan (Capriotti & Frizzell, 2016). The provider ordered a C.T. head scan for D.J. that showed no identification of intracranial abnormality. The provider did not have any other orders following the C.T. head scan.

A fasting blood test and a complete blood count were acquired to support D.J.'s diagnosis. D.J.'s CBC lab values are within the normal ranges. However, D.J.'s glucose level is 133, which is higher than the expected range. D.J. should control his blood glucose level to prevent future attacks from occurring (Belliveau, 2019).

D.J. is taking aspirin to help reduce the risk of recurrent ischemic attacks. He is also taking Norvasc to control his blood pressure. To prevent future transient ischemia attacks, D.J. should limit his sodium intake, limit alcohol consumption, quit smoking, attain a healthy weight, and keep his blood pressure and blood glucose in target ranges (Mayo Clinic, 2020).

Pathophysiology References (2) (APA):

Belliveau, J. (2019). *Signs and symptoms of ministroke (TIA)*. https://www.healthline.com/health/stroke/signs-symptoms-tia-mini-stroke

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspective* (1st ed.). F. A. Davis Company.

Fletcher, J. (2019). *What is the link between diabetes and stroke?*. https://www.medicalnewstoday.com/articles/324924

Mayo Clinic. (2020). *Transient ischemic attack (TIA)*. https://www.mayoclinic.org/diseases-conditions/transient-ischemic-attack/symptoms-causes/syc-20355679

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	N/A	N/A	
Hgb	13.0-16.5	14.4	N/A	
Hct	38.0-50.0	42.0	N/A	
Platelets	140-440	225	N/A	
WBC	4.00-12.00	10.3	N/A	
Neutrophils	40.0-68.0%	N/A	N/A	
Lymphocytes	19.0-49.0%	N/A	N/A	
Monocytes	3.0-13.0%	N/A	N/A	
Eosinophils	0.0-8.0%	N/A	N/A	
Bands	0.0-4.0	N/A	N/A	

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 mmol/L	139	N/A	
K+	3.5-5.0 mmol/L	3.6	N/A	
Cl-	98-108	104	N/A	

CO2	23-29	25	N/A	
Glucose	70-100 mg/dL	133	N/A	Having hyperlipidemia caused increased glucose levels (Pagana et al., 2019).
BUN	8-25 mg/dL	8	N/A	
Creatinine	0.6-1.3 mg/dL	0.63	N/A	
Albumin	3.5-5.2 gm/dL	3.7	N/A	
Calcium	8.6-10 mg/dL	9.0	N/A	
Mag	1.5-2.6	N/A	N/A	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	<1.5 mg/dL	N/A	N/A	
Alk Phos	34-104	N/A	N/A	
AST	10-30 units/ L	N/A	N/A	
ALT	10-40	N/A	N/A	
Amylase	20-86	N/A	N/A	
Lipase	20-86	N/A	N/A	
Lactic Acid	0.5-1.0	N/A	N/A	
Troponin	0-0.4 ng/mL	N/A	N/A	
CK-MB	5-25 IU/L	N/A	N/A	
Total CK	22-198 U/L	N/A	N/A	

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	2-3	N/A	N/A	
PT	F: 9.5-11.3 s M: 9.6-11.8 s	N/A	N/A	
PTT	30-40 s	N/A	N/A	
D-Dimer	≤250 ng/mL	N/A	N/A	
BNP	<125	N/A	N/A	
HDL	40-59	N/A	N/A	
LDL	100-129	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	<150	N/A	N/A	
Hgb A1c	4-5.6%	N/A	N/A	
TSH	0.4-4.0	N/A	N/A	

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	Ambery Yellow clear	N/A	N/A	
pH	5.0-9.0	N/A	N/A	
Specific Gravity	1.001-1.025	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	-0.8 mg/dL	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0.4	N/A	N/A	

RBC	≤2	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

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	N/A	N/A	
PaO2	80-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	95-100%	N/A	N/A	

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	(-) <10,000mL (+) >100,000mL	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Normal upper respiratory tract	N/A	N/A	
Stool Culture	Normal intestine flora	N/A	N/A	

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT head without intravenous contrast.

Diagnostic Test Correlation (5 points): A CT scan provides cross-dimensional images of the brain, providing a more comprehensive inspection of blood circulation and tissue damage. CT scans are a way to determine if a stroke is ischemic or hemorrhagic (Mayo Clinic, 2020).

Diagnostic Test Reference (APA):

Mayo Clinic. (2020). *Transient ischemic attack (TIA)*. https://www.mayoclinic.org/diseases-conditions/transient-ischemic-attack/diagnosis-treatment/drc-20355684

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

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Amlodipine (Norvasc)	Aspirin (Bayer)	Lorazepam (Ativan)	Ziprasidone (Geodon)
Dose	650 mg	5 mg	81 mg	1 mg	20 mg
Frequency	Every 6hrs.	Daily	Daily	Every 6 hrs.	Once
Route	Oral	Oral	Oral	Oral	IM
Classification	Analgesic	Calcium channel blocker	NSAID	Benzodiazepine	Antipsychotic
Mechanism of Action	Reduces production of prostaglandins.	Relaxes coronary and vascular smooth muscles.	Blocks the activity of cyclooxygenase.	Decreases preoperative anxiety and provides amnesia.	Effects mediated by antagonism of dopamine type 2 and serotonin type 2.
Reason Client Taking	To relieve mild to moderate pain.	To control hypertension.	To reduce the risk of recurrent transient	To decrease anxiety.	To decrease schizophrenic behavior.

			ischemic attacks or ischemic strokes.		
Contraindications (2)	-Hypersensitivity -Severe hepatic impairment	-Aliskiren therapy -Hypersensitivity	-Allergy to tartrazine dye -Bleeding problems	-Cross-sensitivity -Sleep apnea	-Hypersensitivity -Oral concentrate contains alcohol
Side Effects/Adverse Reactions (2)	-Hypotension -Hepatotoxicity	-Decreased libido -Arrhythmias	-Confusion -Ecchymosis	-lethargy -Rashes	-Insomnia -Increased sweating
Nursing Considerations (2)	-Use cautiously in pts. with chronic malnutrition. -Monitor renal function and I&O.	-Assess pt. frequently for chest pain. -Monitor BP, hypotension may occur.	-Don't crush aspirin tablets unless directed. -Ask about tinnitus; occurs when blood aspirin levels reach or exceeds maximum dosage.	-Assess degree of anxiety and mental status. -If overdose occurs, flumazenil is the antidote.	-Assess for suicidal tendencies. -Administer as a single dose in the morning or evening.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver function tests – AST, ALT, bilirubin, and creatinine	Monitor BP and pulse, ECG, I&O, and daily weight.	Monitor hepatic function, serum salicylate levels, and uric acid.	Routine evaluation of renal, hepatic, and hematologic function.	Monitor serum potassium and magnesium. Monitor CBC and WBC. Monitor serum prolactin.
Client Teaching needs (2)	-Tell pt. tablets may be crushed or swallowed whole. -Teach pt. signs of hepatotoxicity.	-Suggest taking amlodipine with food to reduce GI upset. -Tell pts. to take missed dose as soon as remembered and next dose in 24hrs.	-Advise pt. not to take with ibuprofen because it may reduce cardioprotective and stroke preventative effects. -Instruct pt. to take aspirin with food or after meals because it may cause GI upset if taken on an empty stomach.	-Instruct pt. to take medication exactly as directed and not to skip or double up on missed doses. -Emphasize the importance to follow-up exams to determine effectiveness of medication.	-Advise pt. to change positions slowly to minimize orthostatic hypotension. -Inform pt. of possibility of extrapyramidal symptoms. Instruct pt. to report these symptoms immediately.

Home Medications (5 required)

Brand/Generic	Hydrocodone-Acetaminophen (Norco)	Lithobid (Lithium Carbonate)	Benztropine (Cogentin)	Sertraline (Zoloft)	Folic acid (Folvite)
Dose	5-325 mg	300 mg	2 mg	50 mg	1 mg
Frequency	Every 8 hrs.	2x Daily	Every morning	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Opioid Analgesic	Antimanic	Anticholinergic	SSRI	Vitamin supplement
Mechanism of Action	Alter the perception of and response to painful stimuli while producing generalized CNS depression.	Influence reuptake of neurotransmitters.	Restores the natural balance of neurotransmitters in the CNS.	Inhibits neuronal uptake of serotonin in the CNS.	Stimulates the production of TBCs, WBCs, and platelets.
Reason Client Taking	To decrease severity of moderate pain.	To prevent or decrease incidence of acute manic episodes.	To reduce rigidity and tremors.	To decrease incidence of panic attacks.	To restore and maintain normal hematopoiesis.
Contraindications (2)	-Hypersensitivity -Respiratory depression	-Cardiovascular disease. -Dehydration	-Hypersensitivity -Tardive dyskinesia	-Hypersensitivity -Oral concentrate contains alcohol	-Aplastic anemia -Pernicious anemia
Side Effects/Adverse Reactions (2)	-Dyspnea -Sweating	-Fatigue -Anorexia	-Blurred vision -Constipation	-Insomnia -Increased sweating	-Rash -Irritability
Nursing Considerations (2)	-Assess bowel function routinely. -Use equianalgesic chart when changing from one opioid to	-Assess pt. for s/s of lithium toxicity. -Initiate suicide precautions if indicated.	-Administer with food or immediately after meals to minimize gastric irritation. -May be crushed and administered	-Assess for suicidal tendencies. -Administer as a single dose in the morning or evening.	-Do not confuse folic acid with folinic acid. -May be given SZ, IM, or IV when PO route is not feasible.

	another.		with food if pt. has difficulty swallowing.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess BP, pulse, and respirations prior administration. Assess type, location, and intensity of pain prior and after administration.	Evaluate renal and thyroid function, WBC, serum electrolytes, serum lithium levels, I&O, and weight.	Assess bowel function, I&O, and extrapyramidal symptoms.	Monitor serum glucose.	Monitor folic acid levels, hgb, hct, and reticulocyte levels.
Client Teaching needs (2)	-Instruct pt. on how and when to ask for and take pain medication. -Encourage pt. to turn, cough, and deep breath every 2hr to prevent atelectasis.	-Instruct pt. to take medication as directed, even if feeling well. -Advise pt. to drink 2-3L of fluid each day.	-May cause drowsiness or dizziness. Advise patient to avoid activities that require alertness. -Caution pt. to change positions slowly to minimize orthostatic hypotension.	-Advice pt., family, and caregivers to look for suicidality. -Advise pt. to avoid alcohol or other CNS depressant drugs during therapy.	-Report rash or difficulty breathing. -Report any pain or discomfort.

Medications Reference (APA):

2019 Nurse's Drug Handbook (2019). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert, very confused, and agitated; Has some distress; looks his age; Appears tired and sleep deprived; Noted to have some spasms which are chronic.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:**	 Skin is within patient's norm. Fair skin; hot & dry; He is not diaphoretic. Temperature is within average range. There is good skin turgor.

Rashes: **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	No rashes, bruises, wounds, or scars; No peripheral edema noted **Braden Score:** 15
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head & neck are symmetrical; trachea is midline without deviation; Auricle is moist and pink without lesions; sclera is white; conjunctive is clear; lids are moist & pink; septum is midline; sinuses are nontender; has no dentition or dentures.
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:**	Faster rate and rhythm (tachycardic); S1 & S2 without murmurs, gallops, or rubs; pulses are 2+ throughout; capillary refill less than 3 seconds.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular even and nonlabored, symmetrical, no wheezes or crackles noted. Clear breath sounds bilaterally.
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:**	Does not eat a regular balanced diet due to living alone and needs feeding assistance. Has a regular diet. H: 5’9” W: 126 lbs. Normal bowel sounds are auscultated in all quadrants. Last BM: After eating lunch at 12:15 PM (diarrhea). Abdomen is soft, non-distended and non-tender. No pain; No masses No incisions, scars, drains, or wounds

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 with no odor. Urinated 240mL. Genitals appear pink and moist.
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 ☒**	CV II-XII are intact; Pt. moves upper extremities but has a dystonic type movement of both upper arms. Pt. has decreased movement of bilateral lower extremities; Poor coordination; No pain, paralysis; No paresthesia; Not pallor; Warm temperature; No swelling or increased pressure; Need supportive devices: wheelchair or thoracic walker; Needs assistance with his ADLs; **Fall Score:** 23
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is alert, but confused and agitated; Patient is a poor historian; Patient has slurred speech; Mild right facial droop noted by may be chronic and secondary to his long-term tardive dyskinesia; Has hallucinations/delusions due to his schizoaffective disorder; Normal sensation; No LOC
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):**	Unable to establish any specific coping methods. It is difficult to determine the client's development level due to his fluctuating demeanor and behavior, but client is able to answer most questions. Client states he is find living alone and his brother checks on him, but his safety is concerning.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0745	123	123/72	18	98.5°F	97%
1100	120	120/74	18	98.5°F	98%

Vital Sign Trends:

Vital signs remained in the range of patient's norm, although is tachycardic.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0745	Numeric	N/A	0	N/A	N/A
1100	Numeric	N/A	0	N/A	N/A

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:**	N/A; Pt. did not have an IV

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
500 mL	Urine – 240 mL Stool (Diarrhea) – 200 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient is alert, however very confused and agitated. Patient denies any pain or SOB when asked. Patient has been oriented to care surroundings. Patient remained on the safety zone for close monitoring as the patient is needing 1:1 care for safety. Patient is monitored closely. Neuro status has been monitored; neuro checks are done every 4hrs. Neuro status remained unchanged from his baseline. No further concerns are noted. Patient is able to sleep in between care periods.

Procedures/testing done: No procedures/testing done.

Complaints/Issues: Patient complained of being hot and bored.

Vital signs (stable/unstable): Vital signs remained stable at his baseline although he is tachycardic.

Tolerating diet, activity, etc.: Patient is able to tolerate diet and activities with assistance.

Physician notifications: No physician notifications.

Future plans for patient: Anticipate patient will be at the hospital less than 2 midnights. Anticipate patient will require extended care facility for rehab.

Discharge Planning (2 points)

Discharge location: The patient will be discharged to a long care term facility since he is unable to perform ADLs on his own.

Home health needs (if applicable): N/A since he is going to ECF.

Equipment needs (if applicable): N/A.

Follow up plan: F/u with PCP at VA in one week.

Education needs: Education on smoking cessation, limiting cholesterol and fat, eating fruits and vegetables, limiting sodium and alcohol, and maintaining a healthy weight.

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. Self-care deficit related to decreased strength and endurance as evidenced by impaired ability to perform ADLs.	The patient needs complete assistance with feeding. He needs some assistance with dressing and toileting. He also needs assistance when getting out of bed.	1. Provide self-help devices: extensions with hooks for picking things up from the floor, toilet riser, and a shower chair. 2. Refer patient to physical and occupational therapist.	The patient cannot perform self-care activities on his own. Patient identifies his brother that can assist him with his needs.
2. Potential for injury related to impaired sensory reception as evidenced by having schizoaffective disorder.	The patient has a past medical history of schizoaffective disorder.	1. Give short, simple messages, or questions and step-by-step directions. Keep conversation on a concrete level. 2. Keep the patient's environment simple to reduce sensory overload and enable concentration on visual cues. Remove distracting stimuli.	The patient is confused, agitated, and remains uncooperative.
3. Disturbed sensory perception related to altered sensory reception as evidenced by altered thought process/bizarre thinking.	The patient has a past medical history of schizoaffective disorder.	1. Speak in a calm, comforting, quiet voice, using short sentences. Maintain eye contact. 2. Ascertain patient's perceptions. Reorient patient frequently to environment, staff, and procedures.	The patient cannot demonstrate behaviors to compensate for/overcome deficits.

4.. Impaired verbal communication related to neuromuscular impairment as evidenced by having schizoaffective disorder.	The patient has a past medical history of schizoaffective disorder and has slurred speech.	1. Speak in normal tones and avoid talking too fast. Give patient time to respond. 2. Consult and refer patient to a speech therapist.	The patient establishes method of communication in which his needs can be expressed.

Other References (APA):

Swearingen P., & Wright, J. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

CC: "Possible facial droop."

D.J. is a 71-year-old Caucasian male. He presents to the hospital with complaints of possible facial droop. D.J. is a poor historian, so there is no history on file. The patient's brother stated that D.J. lives alone and has been battling schizophrenia over the years, and he is on antipsychotics. His brother noted that the patient has some speech slurring, so he has been brought to the V.A. The V.A. brought D.J. to the hospital.

Nursing Diagnosis/Outcomes

Diagnosis #1: Self-care deficit related to decreased strength and endurance as evidenced by impaired ability to perform ADLs.
Outcome: The patient cannot perform self-care activities on his own. Patient identifies his brother that can assist him with his needs.
Diagnosis #2: Potential for injury related to impaired sensory reception as evidenced by having schizoaffective disorder.
Outcome: The patient is confused, agitated, and remains uncooperative.
Diagnosis #3: Disturbed sensory perception related to altered sensory as evidenced by altered thought process/bizarre thinking.
Outcome: The patient cannot demonstrate behaviors to compensate for/overcome deficits.
Diagnosis #4: Impaired verbal communication related to neuromuscular impairment as evidenced by having schizoaffective disorder.
Outcome: The patient establishes method of communication in which his needs can be expressed.

Objective Data

D.J. has a possible facial droop. D.J. cannot walk forward and back on his own and needs assistance for mobilization. He appears to have slurred speech, an altered level of consciousness, and confusion. His pulse rate was 128, BP was 164/113, and glucose was 133. The provider ordered a C.T. head scan for D.J. that showed no identification of intracranial abnormality.

Patient Information

D.J.
Admitted: 6/29/2020
71 years old
Male, Caucasian
Veteran
Single
Allergies: Strawberry Extract
H: 5'9"
W: 126 lbs.
Code: FULL

Nursing Interventions

Diagnosis #1 Intervention:
Provide self-help devices.
Refer patient to a physical & occupational therapist.
Diagnosis #2 Interventions:
Keep conversations on a concrete level.
Remove distracting stimuli.
Diagnosis #3 Interventions:
Use short sentences.
Reorient patient frequently to environment, staff, and procedure.
Diagnosis #4 Interventions:
Give patient time to respond
Consult and refer patient to a speech therapist.