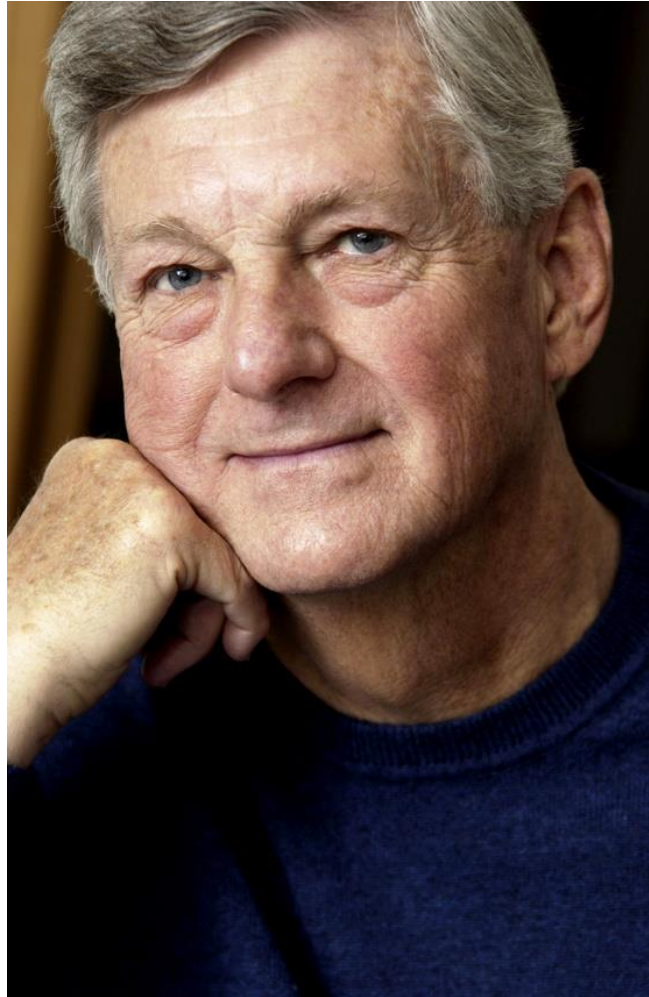


Cerebral Vascular Accident (CVA)



John Gates, 59 years old

Primary Concept	
Perfusion	
Interrelated Concepts (In order of emphasis)	
1. Stress	
2. Coping	
3. Clinical Judgment	
4. Patient Education	
5. Communication	
6. Collaboration	

Cerebral Vascular Accident (CVA)

History of Present Problem:

John Gates is a 59-year-old male with a history of diabetes type II and hypertension who was at work when he had sudden onset of right-sided weakness, right facial droop, and difficulty speaking. He was transported to the emergency department (ED) where these symptoms continue to persist. It has been one hour from the onset of his neurologic symptoms when he presents to the ED. You are the nurse responsible for his care.

Personal/Social History:

John lives with his wife in their own home in a small rural community. He owns a hardware store where he remains active and involved in the day-to-day operations. His wife insists on being by his side and talking to John despite John's frustration in not being able to answer her questions. His wife reports that the past week he has been complaining of episodes where his heart felt as if it was beating irregularly and fast but then resolved. His wife also states that he has been complaining of pain in his right foot the past week. John has been trying to quit smoking the past month and has been using a nicotine patch. His wife reports that he does not regularly check his blood glucose and eats what he wants. He is 6 feet tall and weighs 250 pounds (113.6 kg/BMI of 33.9).

*What data from the histories are **RELEVANT** and has clinical significance to the nurse?*

RELEVANT Data from Present Problem:	Clinical Significance:
RELEVANT Data from Social History:	Clinical Significance:

Patient Care Begins:

Current VS:	P-Q-R-S-T Pain Assessment (5th VS):	
T: 99.2 F/37.3 C (oral)	Provoking/Palliative:	Unable
P: 118 (irregular)	Quality:	
R: 20 (regular)	Region/Radiation:	
BP: 198/94	Severity:	
O2 sat: 99% room air	Timing:	

*What VS data is **RELEVANT** and must be recognized as clinically significant by the nurse?*

RELEVANT VS data:	Clinical Significance:

Current Assessment:	
GENERAL APPEARANCE:	Appears anxious—he is aware and appears to be concerned about changes in neuro status
RESP:	Breath sounds clear with equal aeration bilaterally, nonlabored respiratory effort
CARDIAC:	Pink, warm & dry, no edema, heart sounds irregular—S1S2, telemetry rhythm is atrial fibrillation, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks
NEURO:	Is anxious, restless, and agitated, speech is currently slurred and difficult to understand, facial droop present on right side, pupils equal and reactive to light (PEARL), both right upper extremity (RUE) and right lower extremity (RLE) notably weak (3/5) in comparison to left, which is strong (5/5), right pronator drift present, unable to hold right arm up, right visual deficit cut present
GI:	Abdomen soft/non-tender, bowel sounds audible per auscultation in all 4 quadrants Able to swallow saliva
GU:	Voiding without difficulty, 700 mL urine clear/yellow,
SKIN:	Skin integrity appears intact, right foot not assessed at this time

*What assessment data is **RELEVANT** that must be recognized as clinically significant to the nurse?*

RELEVANT assessment data:	Clinical Significance:

Cardiac Telemetry Strip:



Interpretation:

Clinical Significance:

Radiology Reports: Head CT

*What diagnostic results are **RELEVANT** and must be interpreted as clinically significant by the nurse?*

RELEVANT Results:	Clinical Significance:
No abnormalities noted, no mass, no bleed, no shift present	

Lab Results:

Complete Blood Count (CBC)	Current:	High/Low/WNL?	Previous:
WBC (4.5-11.0 mm ³)	6.8		7.9
Hgb (12-16 g/dL)	14.8		16.1
Platelets(150-450x 10 ³ /μl)	228		201
Neutrophil % (42-72)	71		79

*What lab results are **RELEVANT** and must be recognized as clinically significant by the nurse?*

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Basic Metabolic Panel (BMP)	Current:	High/Low/WNL?	Previous:
Sodium (135-145 mEq/L)	133		139
Potassium (3.5-5.0 mEq/L)	4.1		4.5
Glucose (70-110 mg/dL)	222		128
Creatinine (0.6-1.2 mg/dL)	1.5		1.1
Coag			
PT/INR (0.9-1.1 nmol/L)	1.1		n/a

*What lab results are **RELEVANT** and must be recognized as clinically significant by the nurse?*

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Lab Planning: Creating a Plan of Care with a **PRIORITY** Lab:

Lab:	Normal Value:	Why Relevant?	Nursing Assessments/Interventions Required:
Creatinine Value: 1.5	RED FLAG:		

Clinical Reasoning Begins...

1. *What is the primary problem your patient is most likely presenting?*

2. *What is the underlying cause/pathophysiology of this primary problem?*

(Relate initial manifestations to the pathophysiology of the primary problem)

Pathophysiology of Primary Problem:	Rationale for Manifestations:

Collaborative Care: Medical Management

Care Provider Orders:	Rationale:	Expected Outcome:
Establish peripheral IV 12 lead EKG stat Labetalol 10-20 mg IV prn every 15 minutes to keep SBP 160-180 CT head stat Cardiac monitor continuous NPO Alteplase IV dose per pharmacy (if CT negative for bleed)		

PRIORITY Setting: Which Orders Do You Implement First and Why?

Care Provider Orders:	Order of Priority:	Rationale:
1. Establish peripheral IV 2. Labetalol 10-20 mg IV prn every 15" to keep SBP 160-180 3. CT head stat 4. Cardiac monitor continuous 5. Alteplase IV (if CT negative for bleed)		

Medication Dosage Calculation:

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Labetolol 20 mg IV push (5 mg/mL vial)		IV Push: Volume every 15 sec?	

Medication Dosage Calculation:

Medication/Dose:	Mechanism of Action:	Amount to Safely Administer:	Nursing Assessment/Considerations:
Alteplase 0.9 mg/kg IV over 60 minutes not to exceed 90 mg		Weight: 113.6 kg Amount to administer:	

Collaborative Care: Nursing

3. *What nursing priority(ies) will guide your plan of care? (if more than one-list in order of PRIORITY)*

4. What interventions will you initiate based on this priority?

Nursing Priority:	Nursing Interventions:	Rationale:	Expected Outcome:

5. What body system(s) will you assess most thoroughly based on the primary/priority concern?

6. What is the worst possible/most likely complication to anticipate?

7. What nursing assessments will identify this complication EARLY if it develops?

8. What nursing interventions will you initiate if this complication develops?

9. What psychosocial needs will this patient and/or family likely have that will need to be addressed?

10. How can the nurse address these psychosocial needs?

Evaluation: 1 Hour Later...Alteplase has just completed and the following clinical data is collected:

Current VS:	Most Recent:
T: 99.0 F/37.2 C (oral)	T: 99.2 F/37.3 C (oral)
P: 74 (regular)	P: 118 (irregular)
R: 16 (regular)	R: 20 (regular)
BP: 178/86	BP: 198/94
O2 sat: 96% room air	O2 sat: 99% room air

Current Assessment:	
GENERAL APPEARANCE:	Resting comfortably, appears in no acute distress
RESP:	Breath sounds clear with equal aeration bilaterally, nonlabored respiratory effort
CARDIAC:	Pink, warm & dry, no edema, heart sounds regular with no abnormal beats, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks
NEURO:	Right facial droop no longer present, speech is not as slurred, weakness persists in both RUE and RLE but is stronger (4/5) than before tPA started
GI:	Abdomen soft/non-tender, bowel sounds audible per auscultation in all 4 quadrants
GU:	Voiding without difficulty, urine clear/yellow
SKIN:	Right heel has 1x1 cm stage II pressure ulcer with redness of the entire heel that is blanchable, no drainage noted

1. What clinical data is *RELEVANT* and must be recognized as clinically significant by the nurse?

RELEVANT VS Data:	Clinical Significance:
RELEVANT Assessment Data:	Clinical Significance:

Cardiac Telemetry Strip:

Interpretation:
Clinical Significance:

1. *Has the status improved or not as expected to this point?*

2. *Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment?*

3. *Based on your current evaluation, what are your nursing priorities and plan of care?*

Effective and concise handoffs are essential to excellent care and if not done well can adversely impact the care of this patient. You have done an excellent job to this point, now finish strong and give the following SBAR report to the ICU nurse who will be caring for this patient:

Situation:

Name/age:

BRIEF summary of primary problem:

Background:

Primary problem/diagnosis:

RELEVANT past medical history:

Assessment:

Vital signs:

RELEVANT body system nursing assessment data:

How have you advanced the plan of care?

Patient response:

INTERPRETATION of current clinical status (stable/unstable/worsening):

Recommendation:

Suggestions to advance plan of care:

Education Priorities/Discharge Planning

1. *What educational/discharge priorities will be needed to develop a teaching plan for this patient and/or family?*
2. *How can the nurse assess the effectiveness of patient and/or family teaching and discharge instructions?*

Caring and the “Art” of Nursing

1. *What is the patient likely experiencing/feeling right now in this situation?*
2. *What can you do to engage yourself with this patient’s experience and show that he matters to you as a person?*

Use Reflection to THINK Like a Nurse

Reflection-IN-action (Tanner, 2006) is the nurse’s ability to accurately interpret the patient’s response to an intervention in the moment as the events are unfolding to make a correct clinical judgment.

1. *What did I learn from this scenario?*
2. *How can I use what has been learned from this scenario to improve patient care in the future?*