Brain attack evolve case study

Business

I love my mom so much, and I am so scared. She is all I have. ” How should the nurse respond? A) “ l am sure everything will be all right.

” This response provides false reassurance and does not allow Gail to share her feelings. 3) “ l know this is scary tort you. Would you like to sit and TA This therapeutic response provides acknowledgment of Sail’s fears, and the nurse offers to take time to discuss the situation. C) “ l will notify the chaplain to come and sit with you so you won’t be alone. ” This is passing the buck. The nurse should address Sail’s feelings.

D) “ l am sure your mother knows you are here.

Just keep talking to her. ” This may be therapeutic for Nancy, but it is not therapeutic for Gail. Nursing Interventions ere neurologist diagnoses an chemic left-sided brain attack (stroke). The neurologist determines that Nancy is not a candidate for tissue plainspoken activator (tap). Nonagenarian (Lovelorn) 1 MGM/keg subcutaneously every 12 hours is prescribed.

Nancy weighs 145 pounds. How many MGM of nonagenarian (Lovelorn) will the nurse administer in each dose? (Enter the numerical value only. If rounding is required, round to the whole number). 66 145 pounds divided by 2. 2 keg = 65. 9 keg.

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X 1 MGM/keg = 65. 9 MGM = 66 MGM Ninth a diagnosis of a brain attack (stroke), which priority intervention should the nurse include in Nanny’s plan of care? A) Monitor INNER daily. ere nurse should monitor the OPT level

during heparin therapy. INNER is monitored for Nearing (Commanding) therapy.

3) Assess neurological status every shift. ere neurological status must be monitored more frequently than every 8 or 12 hours as indicate y the Shiite change. C) Evaluate platelet levels daily. Anticoagulants inhibit thrombi formation and do not usually affect platelet levels. D) Keep the head of the bed elevated.

Maintaining a patent airway is essential to support oxygenation and cerebral perfusion. Elevating the head of the bed 30 degrees aids in preventing the tongue from falling backward and obstructing the airway. ere nurse continues to monitor Nanny’s condition closely. 10. Inch finding would require immediate intervention by the nurse? A) Nanny’s cardiac output is less than 4 L/min.

ere normal range for cardiac output to ensure cerebral blood flow and oxygen delivery is 4 to 8 L/min. 3) Nanny’s pulse geometer reading is greater than 95%. A pulse geometer reading of 95% indicates adequate oxygenation to the peripheral tissues.

C) Nanny’s serum potassium level is 3. 9 meg/L.

This potassium level is within normal limits (3. 5-5. 5 meg/L). D) Nanny’s telemetry shows normal sinus rhythm with occasional premature ‘ intraocular contractions. INCORRECT Occasional PVC do not require immediate intervention. Round Nanny’s Sass, potassium level, and telemetry readings are wit in normal limits for her age, her cardiac output is low.

As the nurse assesses Nancy, Gail asks, “ Why isn’t my mother a candidate for thrombosis therapy? ” Inch nursing intervention(s) would be priority at this time? (Select all that apply.) A) Monitor level of consciousness.

Ninth a decreased cardiac output, cerebral perfusion will be affected. This can be reflected in a further decreased level of consciousness. 3) Monitor vital signs every shift.

Ninth a decreased cardiac output, vital signs should be monitored more frequently for signs of shock. Prescribed protocol may even be every 1-2 hours. C) Strict intake and output. ere kidneys use 25% of cardiac output, so when cardiac output is decreased, the kidneys may start failing. Close monitoring is essential. D) Monitor capillary refill every 2-4 hours.

Decreased cardiac output would affect tissue perfusion, reflected in a capillary refill f greater than 3 seconds.

E) Contact physician. ere physician needs to be notified regarding decreased cardiac output to decide Neither to initiate IV fluids if hypothermia is an issue and to determine other medical Interventions. 12. How should the nurse response A) “ l think that is something you should discuss with your mother’s healthcare provider.

” INCORRECT ere nurse has the knowledge and ability to answer the question. 3) “ She is not a candidate because of therapeutic time constraints related to this medication. ” CORRECT Thrombosis therapy is contraindicated in clients with symptom onset longer than 3 ours prior to admission.

Nancy had symptoms for 24 hours before being brought to the medical center. C) “ tap is usually not administered to anyone older than 65 years. ” INCORRECT Irish is false information.

There are certain criteria when thrombosis therapy would not be administered, but age is not one of them. D) “ Since your mother was alert on admission, she is not a candidate to receive this medication. ” INCORRECT This is false information. There are certain criteria when thrombosis therapy would not be administered, but being alert is not one of them. 13. Inch nursing diagnosis has the highest priority? A) Impaired physical mobility.

Although Nancy has right-sided paralysis, that is not the highest priority. 3) Self-care deficit. Although Nancy has facial drooping, that is not the highest priority. C) Impaired social interaction. Although Nancy has difficulty communicating due to the aphasia, that is not the highest priority. D) Impaired swallowing.

According to Mason’s Hierarchy of Needs, physiological needs should be addressed first. Therefore, Nanny’s dysphasia is the highest priority nursing diagnosis since she is at risk for aspiration. Nursing Diagnosis Nancy spends 3 days in the Intermediate Care Unit. Once stabilized, she is rendered to a 40-bed medical unit.

Nancy has right-sided paralysis, facial drooping, global aphasia, and dysphasia.

Her IV fluids are discontinued, but she continues with 20-gauge saline lock, now in the left forearm. She also still has a (Foley) catheter. Other than bedsores, Nanny’s healthcare provider prescribes sitting up in a chair 4 times a day. Because Nancy is right-handed and is having difficulty performing activities of daily living with the left arm, the nurse also includes the nursing diagnosis “ self-care deficit” in the care plan. 14.

Inch intervention would the nurse implement to address this nursing diagnosis?

A) Use narrow grip utensils to accommodate a weak grasp. Node-grip utensils should be used to accommodate a weak grasp. 3) Utilize plate guards when Nancy is eating. Plate guards prevent food from being pushed off the plate. Using plate guards and other assisted devices will encourage independence in a client with a self-care deficit.

C) Discourage Nancy from using assisted devices. Assisted devices can be of great benefit and encourage independence. D) Recommend a regular type toilet seat with grab hand bars. INCORRECT This intervention discourages client independence.