NURSING MANAGEMENT OF PATIENT WITH CEREBRAL VASCULAR ACCIDENT STROKE

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ABSTRACT

Introduction: Cerebral vascular accident has many causes, and risk factor. 80% of the stroke are ischemic, it develop a clout that cut off blood flow to the brain tissues. Atherosclerosis develops with diabetes, its increase the stiffness in the blood vessels, and interrupt with blood perfusion, when the arteries become thin, and pressure increase in blood vessels it cause stroke. Age, high blood pressure and hypercholesterolemia, and positive family history are also leading factor of stroke. Miss Z, also having the positive family history of CVA, her mother was also died with this disease.

Key Words: Cerebal vascular accident; Nursing Management; Pakistan

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CASE SCENARIO

Miss Z, 65 years old, admitted in XYZ Hospital, with complain of left side body weakness. She has the medical history of Diabetics, and Hypertension since last 7 years. She is diagnosed with Ischemic cerebral vascular accident. During hospital care patient become serious, and restlessness, so she was shifted to the Intensive Care Unit for good quality of nursing care, and treatment. Most of the time CVA patient is completely dependent on health care professional due to their self care-deficit care, immobility, difficulty in swallowing, and bathing, so they are more prone to pressure ulcer, and others infection, and they need good quality of care to prevent them from infection. CVA patients are more prone to self care deficit due to their paralysis, and immobility. There are 70% of the patient develops decubitus ulcers with CVA, that are bedridden in hospital, and long-term care services.[1]

PATHO-PHYSIOLOGY

Cerebral vascular accident has many causes, and risk factor. 80% of the stroke are ischemic, it develop a clout that cut off blood flow to the brain tissues.[2] Atherosclerosis develops with diabetes, its increase the stiffness in the blood vessels, and interrupt with blood perfusion, when the arteries become thin, and pressure increase in blood vessels it cause stroke.[3] Age, high blood pressure and hypercholesterolemia, and positive family history are also leading factor of stroke.[4] Miss Z, also having the positive family history of CVA, her mother was also died with this disease.

HISTORY

Miss Z, A 65 year's old female, has medical history of uncontrolled diabetes, and hypertension since last 7 years. She was diagnosed with ischemic brain stroke. She also has the multiple history of Transient ischemic attack in last one year which is evidenced by her C T scan, and MRI Report. Most of the time she missed her medications. She has no previous history of any surgical procedure.

NURSING ASSESSMENT

Miss Z, was in semi-conscious condition, she was unable to speak, un-oriented to place person and time, and with left side body weakness. Major clinical signs of CVA paralysis of body or face, slurred speech, dizziness, low level of consciousness, numbness, and vision problems, are symptoms of stroke.[5] Patent GCS was 8/15, Fever 98.0 F, Pulse 100/min, Respiration 25/min, B.P 160/80 mmhg, oxygen saturation 98 with continue oxygen. Intra-venous inserted on patient left hand. Patient skin warm, moisture to touch, and turgor, mobility was intact, with weak hand grip. Redness and blusters was observed at lower back

and hip side of the body, with watery discharge. She was unable to swallowing, feeding, and positioning without assistant. Patient bowl sound was sluggish, abdomen was hard on palpation, and timpani sound heard on gastric area and dullness on all over the abdomen. Naso-gastric tube and folly catheter were in place. Her urine output was 500-800 ml/24 hours through folly catheter. She was on NG feeding 200ml/hour. More-over her weight was 70 kg. In addition patient was fully dependent for her activity of daily living. According to the physician order patient position change two hourly.

RELATED TREATMENT

The patient was on Intra vascular antibiotics, and antimicrobials to control infection. Antibiotics and antimicrobials help in reducing mortality rate, and infection.[6] The client was on 2 hourly B.P, and sugar monitoring to control further complications. Injection insulin was given to control the hyperglycemia according to the sliding scales. High blood sugar can be well managed with insulin sliding scale.[7] The patient was on tab tenormine to control BP. Injection cleaxine 60mg was given to prevent from thrombosis, and embolism. Anti-platelet and anticoagulant medications can prevent the patients from recurrent stroke.[8] The physcion order that patients position should be changed two hourly to prevent from second degree of bed sore. Patient was on 2 hourly continuing NG feeding for nutrition management.

NURSING CARE PLAN

Nursing diagnose is self care deficit syndrome related to partial paralysis, secondary to CVA.[9] Self care deficit is great challenges for patient with CVA.[10] According to the Carpenito (2009), self care deficit scale is help full to assess the independency of the patient. I assess independency score of my patient; it was 5/5, so my patient need total assistant help. The patient was immobilizing, with skin redness, and difficulty in speaking, and swallowing. More ever, she was on NG feeding. She was unable to attend the toilet, and she need bed pane for passing stool. The short term goal is to assess the patient in daily life activity in each of the area self care, bathing, toileting, dressing, instrument, and feeding.[9]

NURSING INTERVENTIONS

Nursing interventions for this patient is change positioning, perform active Range of motion (ROM) to improve mobility, and prevent her from bed sore. Keep instrument with easy reached and unaffected side of the body. Maintain position during feeding to prevent from aspiration inhalation, and provision proper oral hygiene care. Adequate positioning during NG feeding can prevent the patient from aspiration pneumonia.[9] Keep the patient bed dry, and clean to prevent from skin integrity. Provision of perennial care, and grooming. Encourage the patient to participate in assisting activity. Help the patient in communication, with family and friends. Move the patient from bed to wheel chair.[9] Self care deficit informal teaching was given to the patient, and family. Moreover, after receiving good quality of care in ICU unit, patient GCS was improved, from 8/15 to 12/15, so consultant shifts her in general ward, from ICU. In addition patient was discharge from hospital, and send to the physiotherapist for physiotherapy.

Recommendation

Patient should follow up to the physiotherapist for rehabilitation. Patent BP and sugar should be monitor, after fifteen days by the consultant. Patient physical hygiene should be improved to prevent them from bed-sore and other body infection. We should encourage the patent to participate in ADL, to maximize her independency.

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