Nursing Care Plan: Cerebral Vascular Accident (CVA)

Assessment Data:

1. Sudden numbness or weakness in the face, arm, or leg, especially on one side of the body.
2. Sudden confusion, trouble speaking, or understanding speech.
3. Sudden trouble seeing in one or both eyes.
4. Sudden trouble walking, dizziness, loss of balance, or coordination.
5. Severe headache with no known cause.

Nursing Diagnosis/Problem:

1. **Impaired physical mobility related to hemiparesis, loss of balance and coordination as evidenced by inability to move purposefully within the physical environment.**
2. **Impaired verbal communication related to aphasia as evidenced by difficulty in expressing or understanding language.**
3. **Risk for impaired skin integrity related to immobility and decreased sensation.**
4. **Risk for aspiration related to impaired swallowing function.**

Short Term Goals/Outcomes:

1. The patient will demonstrate improved mobility as evidenced by the ability to move purposefully within the environment with or without assistive devices within one week.
2. The patient will demonstrate effective communication techniques within one week.
3. The patient's skin will remain intact and free from pressure ulcers during the hospital stay.
4. The patient will demonstrate safe swallowing techniques with no signs of aspiration within 48 hours.

Nursing Interventions and Rationales:

1. **Impaired Physical Mobility:**
    - **Intervention:** Assist with active and passive range-of-motion exercises.
        - **Rationale:** To maintain joint mobility and muscle strength.
    - **Intervention:** Encourage the use of assistive devices as needed (e.g., walker, cane).
        - **Rationale:** To promote independence and safety during ambulation.
    - **Intervention:** Reposition the patient every 2 hours.
        - **Rationale:** To prevent complications of immobility, such as pressure ulcers.
2. **Impaired Verbal Communication:**
    - **Intervention:** Use picture boards, gestures, or writing tools to facilitate communication.
        - **Rationale:** To enhance the patient's ability to express needs and preferences.

- **Intervention:** Encourage family members to participate in communication strategies.
  - **Rationale:** To provide emotional support and improve patient outcomes.
- **Intervention:** Refer to a speech therapist.
  - **Rationale:** To receive specialized assessment and intervention to improve communication skills.

3. **Risk for Impaired Skin Integrity:**
   - **Intervention:** Perform skin assessments every shift.
     - **Rationale:** To identify early signs of skin breakdown.
   - **Intervention:** Keep the skin clean and dry; use moisture barrier creams.
     - **Rationale:** To prevent skin irritation and breakdown.
   - **Intervention:** Use pressure-relieving devices such as special mattresses or cushions.
     - **Rationale:** To reduce pressure on vulnerable areas.
4. **Risk for Aspiration:**
   - **Intervention:** Assess the patient's swallowing ability before giving oral intake.
     - **Rationale:** To determine the risk of aspiration.
   - **Intervention:** Position the patient upright during and after meals.
     - **Rationale:** To prevent aspiration by facilitating safe swallowing.
   - **Intervention:** Provide small, frequent meals with appropriate food consistency as recommended by a speech therapist.
     - **Rationale:** To reduce the risk of choking and aspiration.

Evaluation:

1. **Impaired Physical Mobility:**
   - Evaluate the patient's ability to move purposefully within the environment.
   - Assess for any improvements in muscle strength and joint mobility.
2. **Impaired Verbal Communication:**
   - Monitor the patient's ability to use communication aids effectively.
   - Assess for any improvements in verbal or non-verbal communication.
3. **Risk for Impaired Skin Integrity:**
   - Check for any signs of pressure ulcers or skin breakdown.
   - Evaluate the effectiveness of pressure-relieving devices and repositioning strategies.
4. **Risk for Aspiration:**
   - Observe the patient for any signs of aspiration during meals (e.g., coughing, choking).
   - Assess the patient's ability to swallow safely and make necessary adjustments to the diet.

This care plan should be tailored to the specific needs of each patient, considering individual preferences, conditions, and responses to interventions.