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Stroke rehabilitation Initial assessment

Adult Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

63-year-old man after ischemic stroke and acute stabilization. Care stage: At the first supervised assessment.

Medical history: The patient recently had an ischemic stroke and completed initial acute care. Weakness and communication problems now affect daily function. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Weakness on one side and frustration expressing needs.

Objective findings and required checks: Reduced limb strength and speech difficulty; swallowing status needs formal confirmation.

Physical examination and investigations: Review neurological observations, imaging findings, swallowing assessment and rehabilitation evaluations.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Stroke rehabilitation: Focal brain ischemia damages pathways controlling movement, communication and other functions.

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Medical / surgical management

Follow the stroke and swallowing plan, protect skin, support safe movement and communicate accessibly.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed secondary-prevention medicine	Reduce recurrent vascular risk according to stroke type	Check bleeding and drug-specific monitoring
prescribed analgesic	Treat assessed pain	Monitor alertness and function.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Weakness on one side and frustration expressing needs. Reduced limb strength and speech difficulty; swallowing status needs formal confirmation. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize difficulty swallowing with possible aspiration; movement limited by weakness, discomfort or restriction; communication difficulty affecting expression of needs; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Follow the stroke and swallowing plan, protect skin, support safe movement and communicate accessibly. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about coughing with meals, choking and voice changes. Assess: Observe secretion handling and follow a validated swallowing-screen pathway.	Difficulty swallowing with possible aspiration. Possible factors: impaired swallowing coordination or reduced airway protection. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Airway remains protected while an appropriate feeding plan is established. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver follows the assessed swallowing and feeding plan.	1. Withhold oral intake when safety is uncertain and request the appropriate swallowing assessment. Rationale: Unassessed oral intake may cause aspiration. 2. Use only the assessed posture, texture and assistance plan. Rationale: Individual recommendations improve swallowing safety. 3. Maintain oral care and monitor respiratory changes. Rationale: Oral hygiene and early recognition reduce consequences of aspiration. 4. Follow the stroke and swallowing plan, protect skin, support safe movement and communicate accessibly. Rationale: Focal brain ischemia damages pathways controlling movement, communication and other functions. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about usual mobility, fatigue and help needed with	Movement limited by weakness, discomfort or restriction.	Short-term: After the first indicated intervention, at the	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	documented review time: Completes a jointly agreed movement task safely with appropriate assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the home exercise or mobility plan before discharge.	support to ability prevents injury. 2. Plan graded movement, position changes and rest with physiotherapy where indicated. Rationale: Progressive activity supports function while limiting exhaustion. 3. Monitor tolerance and stop for new concerning symptoms. Rationale: Symptoms may indicate unsafe exertion or deterioration.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask the person or caregiver which communication methods work best. Assess: Assess comprehension, expression and the need for qualified interpretation or aids.	Communication difficulty affecting expression of needs. Possible factors: speech, cognition, sensory or language barriers. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Communicates an essential need using an agreed method. Longer-term: Before the clinically approved transition or agreed follow-up: Patient and caregivers demonstrate the communication approach for continuing care.	1. Establish a reliable yes/no or supported communication method. Rationale: A shared method enables participation and reduces frustration. 2. Use qualified interpretation, visual aids or specialist support as indicated. Rationale: Appropriate aids improve accuracy and informed participation. 3. Allow time and verify meaning without completing responses prematurely. Rationale: Respectful pacing supports autonomy and clearer assessment.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching.	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate action in their own	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
gaps.	Validate against the patient's assessment.	words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach safe feeding only after assessment, positioning, rehabilitation goals, prevention medicines and emergency stroke signs. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach safe feeding only after assessment, positioning, rehabilitation goals, prevention medicines and emergency stroke signs.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

New weakness, reduced consciousness, severe headache or respiratory compromise needs urgent stroke reassessment.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Focal brain ischemia damages pathways controlling movement, communication and other functions.

- Priority concerns: Difficulty swallowing with possible aspiration; Movement limited by weakness, discomfort or restriction; Communication difficulty affecting expression of needs; Learning needs about the condition and care plan.

- New weakness, reduced consciousness, severe headache or respiratory compromise needs urgent stroke reassessment.

- Teach safe feeding only after assessment, positioning, rehabilitation goals, prevention medicines and emergency stroke signs.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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