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Home stroke caregiver support Comfort & daily function

Community Health Nursing | Comfort & daily function

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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.

Clinical assessment

Subjective: Caregiver feels unsure about transfers, feeding and prevention medicines.

Objective findings and required checks: Movement and communication limitations persist; swallowing and home support plans need verification.

Physical examination and investigations: Review discharge plan, swallowing recommendations, skin, mobility, medicines and caregiver strain.

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

Clinical focus and pathophysiology

Home stroke caregiver support: Stroke-related deficits can increase aspiration, falls and dependence after discharge.

Medical / surgical management

Demonstrate approved care skills, arrange rehabilitation and coordinate primary-care or community support.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed secondary-prevention medicine	Reduce recurrent vascular risk according to stroke type	Verify adherence and drug-specific precautions
medication reconciliation	Prevent transition errors	Resolve differences with the discharging team.

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

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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: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

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 usual mobility, fatigue and help needed with activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Movement limited by weakness, discomfort or restriction. Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: 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.	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching 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. 4. Demonstrate approved care skills, arrange rehabilitation and coordinate primary-care or community support. Rationale: Stroke-related deficits can increase aspiration, falls and dependence after discharge. 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.

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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: During the next agreed care or activity session: 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.	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 which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	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:	Learning needs about the condition and care plan. Possible factors: new	Short-term: During the next agreed care or activity session: Explains the most	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Use return demonstration for transfers and the assessed feeding plan; explain pressure care and follow-up. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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.

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Health education and continuing care

Use return demonstration for transfers and the assessed feeding plan; explain pressure care and follow-up.

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 stroke signs, choking with breathing difficulty, chest pain or sudden deterioration requires urgent emergency assessment.

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

- Stroke-related deficits can increase aspiration, falls and dependence after discharge.

- Priority concerns: Movement limited by weakness, discomfort or restriction; Difficulty swallowing with possible aspiration; Daily self-care needs exceed current ability; Learning needs about the condition and care plan.

- New stroke signs, choking with breathing difficulty, chest pain or sudden deterioration requires urgent emergency assessment.

- Use return demonstration for transfers and the assessed feeding plan; explain pressure care and follow-up.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

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Nursing Mental Health and Community Concepts, 2e - Open RN / WisTech Open, 2025
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https://wtcs.pressbooks.pub/pharmacology2e/

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