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Difficulty swallowing with possible aspiration Home stroke caregiver support

Community Health Nursing | Focused diagnosis-based template

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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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Focused nursing-problem template

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: At the next patient-specific reassessment: 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. 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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: Difficulty swallowing with possible aspiration.

- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

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

Nursing Mental Health and Community Concepts, 2e - Open RN / WisTech Open, 2025

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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023

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https://www.indiannursingcouncil.org/gazette-notification

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