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Difficulty swallowing with possible aspiration Stroke rehabilitation

Adult 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: 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.

Medical / surgical management

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

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	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.

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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. 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.

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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

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.
- 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: 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/

Health Alterations - Open RN / WisTech Open, 2025

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

https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council

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

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