CVA Nursing Care Plan

Patient Information
Name:
Age:
Date of Admission:
Medical Diagnosis:
History of Present Illness:
Past Medical History:
Nursing Assessment
Neurological Status
Consciousness level:
Orientation:
Pupil reaction:
Muscle strength:
Sensory deficits:
Reflexes:
Cardiovascular Status
Heart rate:
Blood pressure:
Peripheral pulses:
Capillary refill time:
Respiratory Status
Respiratory rate:
Oxygen saturation:
Breath sounds:
Use of accessory muscles:

Mobility and Motor Skills
Range of motion:
Presence of paralysis or paresis:
Coordination:
Communication Abilities
Speech clarity:
Language comprehension:
Ability to express needs:
Swallowing and Nutritional Status
Swallow reflex:
Diet tolerance:
Hydration status:
Skin Integrity
Presence of pressure ulcers:
Skin turgor:
Skin integrity in immobile areas:
Psychosocial Assessment
Emotional status:
Coping mechanisms:
Family support:
Nursing Diagnoses
Goals and Expected Outcomes
Short-term Goals:
Long-term Goals:

Nursing Interventions and Rationale
1. Intervention:
• Rational:
2. Intervention:
• Rational:
3. Intervention:
• Rational:
Evaluation
Response to interventions:
Progress towards goals:
Adjustments to care plan:
Discharge Planning
Follow-up appointments:
Rehabilitation needs:
Home care requirements:
Patient and family education: