

NEUROLOGICAL DISORDERS

P = pathophysiology Dx = Diagnosis
R = Risk Factors N = nursing management
S/sx = Signs + Symptoms C = Complications



Traumatic Head Injury

- P:** A trauma or blunt force hits the skull causing damage to the brain.
- S/sx:** Confusion, agitation, visible head injury, sleepiness, blown pupils.
- N:**
 - Assess for neurological changes or change in level of consciousness. Monitor vital signs.
 - Assess pt. for headache, nausea, vomiting.
 - Check for CSF drainage. Assess pupil size.
- C:** Cerebral bleed, hematoma, ↑ intracranial pressure, infection, seizure, ↑ CO₂ levels, permanent damage.



Seizures

- P:** Abnormal, sudden electrical activity in the brain.
- S/sx:** Uncontrollable involuntary muscle movements (convulsions) or gaze off into the distance with no response to stimuli. May lose consciousness for seconds or minutes. Usually the person will not recall the events leading up to it.
- N:**
 - Assess seizure history. Note time + duration. Prevent injury, but don't restrain. Monitor behavior before + after episode.
 - Turn pt. on side at end of seizure to drain secretions.
- C:** Status epilepticus - epileptic spasms without any rest periods which can result in brain damage.
- R:** Genetic inheritance, Brain trauma, tumors, toxic, metabolic disorders or infection.

Parkinson's Disease

- P:** Decreased dopamine levels in the brain cause neurological + musculoskeletal sx.
- N:**
 - Monitor swallowing activity + neuro activity. assist w/ ambulation.
 - Promote PT - or so preserve function.
 - Increase fluid intake by 2L/day.
- C:** Falls, Self-care deficits, depression, constipation, and poor posture.



Stroke



- P:** Neurological deficit caused by a block of blood flow to the brain.
- S/sx:** One sided weakness, facial drooping, confusion, slurred speech, or aphasia.
- Dx:** CT Scan Or MRI Confirms + identifies type of stroke which determines treatment.
- R:** Atherosclerosis, hypertension, diabetes, stress, obesity, oral contraceptives, anticoagulation therapy.
- N:**
 - Airway is priority. Monitor VS, LOC, pupils + reflexes.
 - position client on side to prevent aspiration.

Types of Stroke

- Ischemic**
↳ an obstruction of a blood vessel
87% of stroke cases
- Hemorrhagic**
↳ a weakened blood vessel ruptures
Risk factor = Hypertension
- TIA (Transient Ischemic Attack)**
↳ temporary CLO+ that resolves on its own
A warning sign for stroke

Multiple Sclerosis

- P:** a central nervous system disease characterized by demyelination of axons.
- S/sx:** Fatigue, weakness, ataxia, vertigo, tremors, blurred vision, emotional changes, & sensation, bladder + bowel disturbances, @Babinski reflex.
- Dx:** Requires extensive neurological testing over many years of a slow onset of disease.
- N:**
 - Provide energy preservation measures.
 - Encourage independence while providing safety.
 - Monitor for urinary + bowel dysfunction.
- C:** Falls, psychological problems, & mobility.

Meningitis

- P:** inflammation of the meninges + pia mater of the central nervous system. Usually caused by bacteria or a virus.
CSF is tested for the pathogen and used to determine the treatment.
- S/sx:**
 - LOC, Red macular rash, pain with neck flexion.
- N:** Monitor for seizures. Assess cranial nerves.

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Nursing Assessment (Speedy Study Guides) Speedy Publishing, 2014-07-03 A Nursing Assessment Guide is a comprehensive work to outline the procedures nurses use to properly assess patients to determine a patient's needs and apparent state of health. It provides a clear blueprint of procedures to follow and outlines the most practical order to follow them. Proper technique is described in detail and it has illustrations and diagrams for doing things the correct way for the comfort of the patient and good assessment of possible problems. It is a helpful reference for clear and concise charting.

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