IOSR Journal of Nursing and Health Science (IOSR-JNHS)
e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 13, Issue 3 Ser.2 (May. – June. 2024), PP 33-35
www.iosrjournals.org

Systematization Of Nursing Care For An Elderly Woman With Cerebral Vacular Accident

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Abstract:
Cerebral vascular disorders, notably stroke, represent a critical dysfunction of the central nervous system, triggered by disorganization of cerebral blood flow. Through the systematization of care, it is possible to develop specific interventions to treat complications resulting from the disease, such as compromised mobility, deficits in self-care and changes in communication and swallowing. The study aims to systematize nursing care for an elderly woman with a stroke. In the clinical case presented, an elderly patient was admitted with an ischemic stroke, requiring complex and individualized care. Nursing diagnoses were established and interventions were implemented to address their specific needs, such as mobilization, hygiene, feeding and control of vital signs. However, despite the efforts of the nursing team, the patient persisted without significant improvements in her clinical condition. Despite the challenges faced, the systematization of nursing care remains an essential tool for providing quality care targeted to the needs of individuals affected by stroke.
Key Word*: Stroke; Systematization of Nursing Care; Nursing.*

Date of submission: 16-05-2024 Date of acceptance: 26-05-2024

I. Introduction

Cerebrovascular disorders is a general term for a functional abnormality of the central nervous system (CNS) that occurs when the brain's normal blood supply becomes disorganized. Stroke is the leading brain disorder in the United States and worldwide [1].

Stroke can be caused by two distinct mechanisms, if we consider its pathophysiology: ischemia (85%) or hemorrhage (15%). Ischemic stroke occurs when there is a lack of blood supply to the brain, often caused by the formation of an atherosclerotic plaque or the presence of a clot that arrives through the circulation from another part of the body. Atherosclerosis produces plaque formation and progressive vessel stenosis. Cerebral thrombosis refers to the formation or development of a blood clot or thrombus within the cerebral arteries, or their branches, which displace, producing occlusion and ischemia. Hemorrhagic stroke occurs due to the rupture of a blood vessel and consequent blood leakage. Hemorrhage can be intracerebral or subarachnoid. In both cases, the lack of blood supply causes an infarction in the area supplied by the vessel and the cells die [2].

Regarding the risk factors for stroke, they are grouped into two groups, those considered treatable and those not treatable. Those that cannot be treated are aged over 60 years, black race, positive family history and previous stroke. The treatable ones are high blood pressure, cardiovascular disease, diabetes mellitus, smoking, alcohol consumption, obesity and physical inactivity, diet [3].

According to data from the World Health Organization (WHO), stroke is the second leading cause of death in the world, occurring predominantly in middle-aged and elderly adults. In 2005, the disease was responsible for 5.7 million deaths worldwide, equivalent to 9.9% of all deaths. The majority of these deaths occurred in inhabitants of low- and middle-income countries and 2/3 occurred in people over 70 years of age. In Brazil, it is currently the main cause of death, being responsible for more than 90 thousand deaths/year, considered the highest rate in Latin America. In addition to high mortality, it is a highly disabling disease, responsible for motor, speech and swallowing sequelae [4].

Symptoms of a stroke are usually sudden and may include numbness or weakness on one side of the body, facial weakness, dizziness, difficulty walking or understanding others, and severe headaches [5].

Stroke presents itself as a disease with high disabling potential, present, especially, in age groups over 60 years old. For these individuals, in turn, there are physiological changes inherent to age, such as decreased muscle strength and deep tendon reflexes, as well as difficulty in body balance and changes in gait [5].

The diagnosis of stroke is based on the clinical picture and neurological examination, complemented by imaging workup. The most commonly used imaging study in the acute phase is computed tomography of the skull, without the use of contrast, which can show, depending on the type of evolution, type of stroke and the territory involved, anything from a normal exam to changes in the parenchyma [6].

As a professional, nurses play an important role in assisting seriously ill patients, especially those with stroke. Nursing care is essential for these patients, as the nurse remains attentive throughout the rehabilitation treatment process, preventing or detecting complications early, with the aim of achieving the patients' well-being and, thus, promoting health. health [6].

The nurse must work with the nursing process in the most diverse health and illness situations and, therefore, must use it in the care of patients with stroke. In general, people with this disease have, among their disabilities, affected mobility. This is seen from a functional perspective, due to the individual's inability to move freely. Although physical limitation can manifest itself suddenly or slowly, depending on its extent and duration, it can be a contributing factor to a series of health problems, ranging from self-care deficits to impaired social interaction [5].

Therefore, the study aims to systematize nursing care for an elderly woman with a stroke.

II. Systematization Of Nursing Care

Patient, 78 years old, female, hypertensive and diabetic, was admitted to hospital at 9:00 am, with suspected stroke. She was comatose, with aphasia, paresis in the upper and lower limbs, only responding to small stimuli, such as when puncturing an access. Does not respond to verbal commands and spends most of the time with his eyes completely closed. A physical examination and imaging examination (computed tomography) were performed to confirm the diagnosis. The tests confirmed that it was an ischemic stroke.

The patient uses Piracetam (cintilan®), Furosemide, Losartan Potassium, Dipyrone sodium, Ceftriaxone, Omeprazole and Metoclopramide . During the hospitalization period, nursing diagnoses were listed and follow-up interventions were outlined, as shown in frame 1.

Frame 1. Nursing diagnoses and interventions

NURSING DIAGNOSTICS	NURSING INTERVENTIONS
Impaired physical mobility related to loss of coordination and balance, spasticity, and brain injury evidenced by limited range of motion.	- Position the patient correctly to avoid contractures; - Use measures to relieve pressure (cushions, pillows, changing position); - Maintain good body alignment and prevent compressive neuropathies; - Change position every 2 hours. - Establish an exercise program for the patient;
Self-care deficits (bathing, taking care of hygiene, using the bathroom, dressing, grooming and eating) related to stroke sequelae evidenced by inability to eat food, inability to bathe, inability to perform body hygiene adequate, inability to dress.	- Perform a bed bath every day; - Comb hair after bathing; - Perform oral hygiene; - Perform nasogastric tube for feeding.
Altered cerebral perfusion related to the effects of ischemic stroke evidenced by reduced level of consciousness.	- Provide adequate ventilatory support; - Offer an adequate amount of oxygen to the patient; - Maintain oxygen saturation greater than 94%; - Identify signs of increased ICP.
Impaired swallowing related to decreased swallowing movement evidenced by neuromuscular injury.	- Observe the patient for paroxysms of coughing, food running or accumulating on one side of the mouth, food retained for a long period in the mouth or nasal regurgitation when swallowing liquids; - Monitor the patient for the risk of aspiration pneumonia, dehydration and malnutrition; - Perform a nasogastric tube if prescribed;
Altered urinary elimination (incontinence or retention) related to altered neurological perception and neurological control evidenced by urinary retention or incontinence.	- Examine/palpate the bladder periodically; - Perform an indwelling bladder catheterization, if prescribed; - Perform bladder training as soon as the patient is conscious. - Perform water balance for 2/2 hours;
Altered sensory perception related to altered reception, transmission and/or sensory integration evidenced by changes in visual acuity, impaired communication.	- Perform sensory stimulation; - Make eye-to-eye contact with the patient; - Increase natural or artificial lighting in the patient's location; - Touch the patient and talk to the patient; - Guide the patient regarding the time and space of 8/8 hours;
	- Carry out assessment to outline the patient's deficits;

Altered thought processes related to brain injury, mental confusion, or inability to follow instructions	- Structure, together with other professionals, a cognitive-perceptual training program, visual images, guidance regarding reality and procedures; - Transmit confidence and hope to the patient;
Impaired verbal communication related to brain injury evidenced by difficulty expressing thoughts verbally.	- Assess the patient with the speech therapist; - Describe the exact deficit and suggest the best method for communication; - Talk to the patient during any procedure.
Risk of impaired skin integrity related to decreased mobility	- Change position every 2 hours, if possible; - Place cushions under the bony prominences; - Reduce pressure on the most prominent locations. - Keep skin clean and dry; - Use mineral oil;

It is noteworthy that the study had the companion's agreement through signing the Free and Informed Consent Form (TCLE), following Resolution 466/2012 of the National Health Council (CNS).

III. Conclusion

Carrying out this case study made it possible to deepen knowledge about stroke, allowing a better understanding of its pathophysiology, types, causes, risk factors, signs and symptoms, treatments and rehabilitation.

The most significant aspect of this investigation was understanding how nursing should act when dealing with patients who have suffered a stroke. It is recognized that the application of the systematization of nursing care is fundamental to providing patients with quality care targeted at their main needs.

The patient's condition remains unchanged, presenting hypotension, paresis in the upper and lower limbs, lack of communication, lack of eye opening and continues to receive hyposodium feeding through a nasogastric tube, with an indwelling urinary catheter, under nursing care.

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