

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 CLOT 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.

Notes 15 Guide

Ying-Ying Zheng



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Table of Contents Notes 15 Guide

1. Understanding the eBook Notes 15 Guide
 - The Rise of Digital Reading Notes 15 Guide
 - Advantages of eBooks Over Traditional Books
2. Identifying Notes 15 Guide
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Notes 15 Guide
 - User-Friendly Interface
4. Exploring eBook Recommendations from Notes 15 Guide
 - Personalized Recommendations
 - Notes 15 Guide User Reviews and Ratings
 - Notes 15 Guide and Bestseller Lists
5. Accessing Notes 15 Guide Free and Paid eBooks

- Notes 15 Guide Public Domain eBooks
- Notes 15 Guide eBook Subscription Services
- Notes 15 Guide Budget-Friendly Options
- 6. Navigating Notes 15 Guide eBook Formats
 - ePub, PDF, MOBI, and More
 - Notes 15 Guide Compatibility with Devices
 - Notes 15 Guide Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Notes 15 Guide
 - Highlighting and Note-Taking Notes 15 Guide
 - Interactive Elements Notes 15 Guide
- 8. Staying Engaged with Notes 15 Guide
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Notes 15 Guide
- 9. Balancing eBooks and Physical Books Notes 15 Guide
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Notes 15 Guide
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Notes 15 Guide
 - Setting Reading Goals Notes 15 Guide
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Notes 15 Guide
 - Fact-Checking eBook Content of Notes 15 Guide
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development

- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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