Additional Information for Nursing:

Nursing:

As BA's primary nurse, you assess her right arm and right lower leg weakness and inability to use her fine motor skills in signing her name for consent of treatment. When you administer BA her morning medication, she mentioned that sometimes she was not the best at remembering some of her medications. She was able to recall the majority of her medications and she recognized the remaining meds when you said their name. However, she only knew she was taking aspirin to prevent another stroke and her inhalers for her "breathing" and her "hydrocodone when her knees ached real bad". She knew she was on meds for her "pressure" and diabetes but was not clear which one was for what. She tells you that she is not sure the she will be able to give herself that "diabetes shot".

You notice that BA has few visitors. In visiting with BA about going home, you discover that she lives alone in an apartment and has never been married. Her apartment is on one level but there are several steps to get into the front door. She has expressed concern about "getting around" at home, and is hopeful that her time at the skilled nursing facility will get her stronger so she can manage on her own at home and get back to church.

Questions:

1. What education does BA need regarding her medications before she can return home? What suggestions do you have to assist BA in taking her medications correctly?
2. What additional assessment need to made regarding BA's ability to give her insulin injections? What other professionals would you want to coordinate for this assessment and teaching?
3. What additional assessments of the home needs to be made before the patient can return to her home? What professionals would you want to consult to prepare the home for BA?
4. In coordinating the transition-of-care planning, how will you coordinate care of all of the professionals that are working with BA to assist her transition from hospital to skilled nursing facility to home?