Nursing Problem Worksheet

Name: Chloe Sylvester

Anticipated Patient Problem and Goals	**Relevant Assessments** (Prework) What assessments pertain to your patient's problem? Include frequencies	**Multidisciplinary Team Intervention** (Prework) What will you do if your assessment is abnormal?
Problem: Risk for unstable blood glucose Reasoning: newly dx DM, carb controlled diet, up ad lib, drinks a few white claws every week Goal: Will main a BG of 70-110 during my care. Goal: will verbalize good nutritional/ diet choices to make after d/c during my care.	assess blood glucose QIDACHS	administer insulin 10 units ACHS and lispro utilizing low sliding scale ACHS subq administer glargine 22 units subq at bedtime
	assess % of meal intake at each meal time	encourage to eat proteins, vegetables, etc. before simple carbs
	assess activity, tolerance OOB PRN	Educate importance of regular activity and exercise
	(Continuous) Assess for signs of hyperglycemia: polyuria, polydipsia, polyphagia	if BG > 600, obtain stat serum glucose notify provider
	(Continuous) Assess for signs of hypoglycemia: dizziness, increased HR, confusion	50-69 - give simple carb ex: 4oz juice, recheck in 15min, repeat until BG > 70 and notify provider. Check BG 1hr post 70 reading. IF unresponsive- admin glucagon 1mg IM
	assess knowledge about alcohol use, diet, impact on blood glucose SID	educate on good nutritional choices: whole grains, vegetables, low fat dairy, including exercise into lifestyle, monitoring BG at home, limiting alcohol

Anticipated Patient Problem and Goals	**Relevant Assessments** (Prework) What assessments pertain to your patient's problem? Include frequencies	**Multidisciplinary Team Intervention** (Prework) What will you do if your assessment is abnormal?
Problem: Deficient Fluid Volume Reasoning: N/V, weakness, DKA Goal: Skin turgor and mucosa will remain elastic and moist during my care. Goal: urine output will be =/> 30mL/hour during my care	Assess skin turgor for elasticity or tenting BID	Administer / Maintain IV fluids NS @ 75mL/hr continuously Encourage fluid intake of preferred beverage
	Assess mucous membranes q4	Provide supplies for oral care, chapstick to prevent ulcers, irritation
	Assess for dizziness upon sitting, standing PRN	Dangle, change positions slowly, educate safety importance, use call bell
	Assess presence of nausea, vomiting, abd pain q2	notify RN, provide emesis basin, ambulate to restroom
	Assess HR, rhythm, BP q8	administer KCl 20 MEQ PO SID
	Assess urine output - amount, color, clear/ cloudy q8	Provide frequent toileting opportunities, continue IV fluids or encourage intake