

N321 Care Plan #3

Lakeview College of Nursing

Jessica Kavajecz

Demographics (3 points)

Date of Admission 11/19/20	Patient Initials DD	Age 30	Gender Female
Race/Ethnicity Caucasian	Occupation Stay at home mom	Marital Status Married	Allergies NKA
Code Status Full	Height 5ft 2 in	Weight 165 pounds	

Medical History (5 Points)

Past Medical History: Hypertension, High cholesterol, and migraines. In her last pregnancy she had gestational diabetes.

Past Surgical History: Gallbladder removal 15 years ago, C-section in 2010.

Family History: Mother and father- both have hypertension. Father is diabetic and has sleep apnea.

Social History (tobacco/alcohol/drugs): Client smokes a few cigarettes daily, does not drink or do illegal drugs.

Assistive Devices: Client does not use assistive devices.

Living Situation: Client lives at home with her husband and two sons (ages 10 & 7).

Education Level: Client has a high school diploma.

Admission Assessment

Chief Complaint (2 points): Client came into the ED with dizziness and feeling as though she could “not stay awake”.

History of present illness (2 points): Onset: Client has been experiencing these symptoms for a few weeks. Location: All over the body. Pain in stomach. Duration: The past month.

Characteristics: The client feels weak and tired all of the time. **Associated manifestations:** With the weakness, the client is also experiencing headaches, nausea / vomiting, frequent

urination, and feeling thirsty. Relieving factors: The client has not done anything to relieve these symptoms. Treatment: The client has not sought out treatment until now. Upon admission, the clients pulse was 72 bpm, respiratory rate of 22, blood pressure of 140/88, temperature of 97.4, and an O2 percentage of 96%.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):. Type II Diabetes.

Secondary Diagnosis (if applicable):. Hypertension.

Pathophysiology of the Disease, APA format (20 points):

Pathophysiology References (2) (APA):

Type II diabetes occurs when your body resists insulin. Insulin is the hormone in our bodies that control glucose (sugar) levels. When normal glucose levels are not maintained, the body is impaired and can have complications (Mayo Clinic, 2020). Type I and type II diabetes is different because type I is typically diagnosed in childhood and the exact cause is unknown (5% of the diabetic population), in type II the body is resisting insulin due to lifestyle factors (risk factors) like obesity, genetics, sedentary lifestyle, or gestational diabetes. Type II diabetes makes up 95% of the diabetic population. Some signs and symptoms of Type II diabetes include increased thirst, increased hunger, increased urination, fatigue, blurry vision, unexplained weight loss, slow-healing sores, frequent infections, and dark areas on the skin (Mayo Clinic, 2020). A patient who has type II diabetes would have a high A1C level. An A1C looks at your average blood sugar level going back three months. Normal A1C levels are considered to be below 5.7%, but in a

diabetic 7% or below is what we would want to see. On admission, the clients A1C level was 12.8%. In lab results, the glucose level would also be high. Normal range is 70-100 and on admission the client's glucose level was 560 (finger stick in the ED). These blood tests would diagnose a patient who has diabetes. Since the Clients glucose levels were so high, 20 units of fast acting (novolog) insulin was given. Type II diabetes holds risk of complications because it effects the entire body. For example, the kidneys (can go into failure), nerves (nerves can be damaged), eyes (eyesight is compromised), heart, and hearing can be effected. A diabetic patient can also go into hyperglycemia (when glucose levels are high) or hypoglycemia (when glucose levels are low). Hyperglycemia and hypoglycemia hold more risks and complications to the client. That is why maintaining glucose levels are important. A diabetic client would be encouraged to lose weight, eat healthier, and exercise. Doing these things would help prevent complications and improve the quality of life (Capriotti and Frizzell, 2016). To manage diabetes, the client would need insulin daily. The client came into the ED with complaints of fatigue, headache, dizziness, nausea, vomiting, frequent urination, and increased thirst. The client also complained of abdominal pain. With the blood sugar of 560, and A1C of 12.8% insulin was administered as well as 0.9% normal saline and Toradol for abdominal pain. After pain medication was administered the client's blood pressure was 130/86, 76 HR, RR of 20, O2 at 97%, temperature of 98.0, and a pain level 3/10.

References:

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Mayo Clinic. (2020, August 26). *Type 2 diabetes*. <https://www.mayoclinic.org/diseases-conditions/type-2-diabetes/symptoms-causes/syc-20351193>.

Laboratory Data (15 points)

CBC **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.90-4.98	8 million		If client has diabetes, RBC's can be high (Capriotti and Frizzell, 2016).
Hgb	12.0-15.5	20 mg/dl		If client has diabetes, Hgb can be elevated (Capriotti and Frizzell, 2016).
Hct	35-45	56%		If client has diabetes, Hct can be elevated (Capriotti and Frizzell, 2016).
Platelets	140-400	420,000		Platelets can be elevated in type II diabetes (hyperglycemia can be a factor) (Capriotti and Frizzell, 2016).
WBC	4.0-9.0	12,000		WBC can be elevated due to infection. Diabetes can cause an elevated WBC count (Capriotti and Frizzell, 2016).
Neutrophils	40-68%	85%		If client has diabetes, neutrophils can be elevated (Capriotti and Frizzell, 2016). The first response to infection.
Lymphocytes	18-49%	45%		
Monocytes	3.0-13.0%	12%		
Eosinophils	0.0-8.0%	5%		
Bands	0.0-1.0%	2%		If client has diabetes, bands can be elevated (Capriotti and Frizzell, 2016).

Chemistry **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	159		If client has diabetes, kidneys can be impaired which can complicate the excretion of excess sodium (Capriotti and Frizzell, 2016).
K+	3.5-5	2.5		The client was urinating frequently and vomiting which can cause low potassium (dehydration) (Capriotti and Frizzell, 2016).
Cl-	95-105	102		
CO2	21-31	NA		Not listed
Glucose	70-110 mg/dl	601		The client has diabetes, So her glucose level is high.
BUN	7-25 mg/dL	26		BUN can be elevated due to the kidneys being compromised (diabetes complication) (Capriotti and Frizzell, 2016).
Creatinine	0.50-1.20 mg/dL	0.6		
Albumin	3.5-3.7 g/dL	3.5		
Calcium	8.8-10.2 mg/dL	9.2		
Mag	1.5-2.6 mg/dL	2.2		
Phosphate	2.5-4.5 mg/dL	NA		Not listed
Bilirubin	0.2-0.8 mg/dL	1.1		Bilirubin can be elevated due to diabetes complications (Capriotti and Frizzell, 2016).
Alk Phos	32-104 U/L	105		Alk Phos is slightly elevated from liver complications from diabetes (Capriotti and Frizzell, 2016).
AST	10-40	34		

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ALT	10-30	36		ALT can be elevated as a result of liver complications caused from diabetes (Capriotti and Frizzell, 2016).
Amylase	23-85 u/L	NA		Not listed
Lipase	12-70 u/L	NA		Not listed
Lactic Acid	0.5-1 mmol/L	NA		Not listed

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.8-1.4	NA		Not listed
PT	10.1-13.1 sec	NA		Not listed
PTT	25-36 sec	NA		Not listed
D-Dimer	<0.5	NA		Not listed
BNP	<100 pg/mL	NA		Not listed
HDL	>60 mg/dL	NA		Not listed
LDL	<100 mg/dL	NA		Not listed
Cholesterol	<200 mg/dL	NA		Not listed
Triglycerides	<150 mg/dL	NA		Not listed
Hgb A1c	<7%	NA		Not listed
TSH	0.4-4.0 mu/L	NA		Not listed

Urinalysis **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
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Color & Clarity	Yellow/Clear	NA		Not listed
pH	4.2-8.0	NA		Not listed
Specific Gravity	1.005-1.030	NA		Not listed
Glucose	Negative	NA		Not listed
Protein	0-8 mg/dL	NA		Not listed
Ketones	Negative	NA		Not listed
WBC	0-4	NA		Not listed
RBC	0-2	NA		Not listed
Leukoesterase	Negative	NA		Not listed

Cultures **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	NA		Not listed
Blood Culture	Negative	NA		Not listed
Sputum Culture	Negative	NA		Not listed
Stool Culture	Negative	NA		Not listed

Lab Correlations Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

A1C- 12.8%

CT of abdomen- Normal result.

ECG- showed normal sinus rhythm.

Diagnostic Test Correlation (5 points): The client had extra diagnostic testing. An A1C was performed because the client was diagnosed with diabetes on admission. An A1C looks at the average blood glucose level from the past three months (Mayo Clinic, 2020). An ECG shows the electrical signals of your heart (Capriotti and Frizzell, 2016). An ECG is often ordered for patients who come in with a variety of symptoms to rule out cardiac issues.

Diabetes is also hard on the body, so looking at heart function is important. The CT of the abdomen was ordered because the patient had abdominal pain, but the CT was normal.

Diagnostic Test Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Mayo Clinic. (2020, August 26). *Type 2 diabetes*. <https://www.mayoclinic.org/diseases-conditions/type-2-diabetes/symptoms-causes/syc-20351193>.

Current Medications (10 points, 1 point per completed med)

10 different medications must be completed

Home Medications (5 required)

Brand/ Generic	Zestril / Lisinopril	Altoprev / Lovastatin	Ortho- Novum / norethindrone and ethinyl estradiol	Multivitami n- Women's 1 a day	Tylenol / Acetaminop hen
Dose	10mg	20mg	0.75mg	1 pill	650mg
Frequency	1X Daily	1X daily at bedtime.	1X daily at the same time each day.	1X daily.	PRN
Route	Orally	Orally	Orally	Orally	Orally
Classification	Antihyperte nsive / ACE inhibitors.	Antilipemic s / HMG- CoA reductase inhibitors.	Contraceptive / Progestin's.	Vitamin	Analgesic
Mechanism of Action	Decreases the production of angiotensin II and a suppression of the RAAS.	Inhibits HMG-CoA reductase, an early step in cholesterol synthesis.	Suppresses ovulation by inhibiting pituitary gonadotropin secretion, and forms thick cervical mucus.	Used to promote growth and good health.	Produces analgesia by inhibiting prostagland in and other substances that sensitize pain receptors.
Reason Client Taking	Client taking for hypertensio n.	Client is taking for high cholesterol.	Client is taking for birth control.	To promote health.	To relieve pain.

<p>Contraindications (2)</p>	<p>Use cautiously in patients with impaired renal function—adjust dosage. Contraindicated in patients hypersensitive to ACE inhibitors and in those with a history of angioedema related to previous treatment with ACE inhibitor.</p>	<p>Contraindicated in patients hypersensitive to drug and those with active liver disease. Use cautiously in patients who consume alcohol.</p>	<p>Contraindicated in patients hypersensitive to drug, contraindicated in those who have breast cancer. Use cautiously in those who have diabetes.</p>	<p>Contraindicated in patients who have an allergy to the vitamin, and if there is too much iron in the body.</p>	<p>Contraindicated in patients who have liver failure. Use cautiously in patients with long-term alcohol use.</p>
<p>Side Effects/ Adverse Reactions (2)</p>	<p>Dizziness, Hypotension .</p>	<p>Headache, abdominal pain or cramps.</p>	<p>Stroke, Thromboembolism.</p>	<p>Allergic reaction (hives, itching), upset stomach (nausea / vomiting).</p>	<p>Hypokalemia, Hypoxia.</p>
<p>Nursing Considerations (2)</p>	<p>Monitor BP frequently. Monitor WBC with differential counts before therapy, 2 weeks for the first 3months of therapy, and periodically after.</p>	<p>Have patient follow a diet restricted in saturated fat and cholesterol during therapy. Obtain LFT results at the start of therapy.</p>	<p>Monitor BP, watch patient closely for signs of edema.</p>	<p>Make sure vitamin does not interact with any current medications . Consult with physician.</p>	<p>Consider reducing total daily dose and increasing dosing intervals in patients with hepatic or renal impairment . Many OTC medications contain</p>

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					acetaminophen, so be aware of this when calculating total daily dose.
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Hospital Medications (5 required)

Brand/ Generic	Novolog / Insulin	0.9% sodium chloride	Glucophage/ Metformin	Levemir / Insulin	Toradol / Ketorolac
Dose	Per sliding scale.	100 ml/hr	1000mg	10 units	15 units
Frequency	Before meals and bedtime (after blood sugar check).	continuous	2X daily	1X daily (in the evening).	PRN every 4-6 hours.
Route	Sub-Q	IV	Orally	Sub-Q	IV push
Classification	Antidiabetic	mineral and electrolyte replacements/sup plements	Antidiabetic.	Antidiabetic.	NSAID, analgesic.
Mechanism of Action	Lowers blood glucose level by stimulating peripheral glucose uptake by	Sodium is a major cation in extracellular fluid and helps maintain water distribution, fluid	Decreases hepatic glucose production and intestinal	Lowers blood glucose level by stimulating peripheral	Blocks cyclooxygenase, an enzyme needed to synthesize

	binding to insulin receptors on skeletal muscle and in fat cells and by inhibiting hepatic glucose production.	and electrolyte balance, acid-base equilibrium, and osmotic pressure.	absorption of glucose and improves insulin sensitivity.	glucose uptake by binding to insulin receptors on skeletal muscle and in fat cells, and by inhibiting hepatic glucose production.	prostaglandins. This blocks pain.
Reason Client Taking	Client is taking for diabetes.	Client taking to replenish electrolytes.	Client is taking for diabetes.	Client is taking for diabetes.	Client is taking for pain.
Contraindications (2)	Contraindicated during episodes of hypoglycemia, Inhaled insulin is contraindicated in patients with active lung cancer.	Hypertonic (3%, 5%) solutions should not be used in patients with elevated, slightly decreased, or normal serum sodium; Fluid retention or hypernatremia.	Metformin-associated lactic acidosis has resulted in death, avoid using drug in patients with clinical or laboratory evidence of hepatic disease.	Contraindicated during episodes of hypoglycemia or diabetic ketoacidosis, contraindicated in patients hypersensitive to drug or its components.	Advanced renal impairment or risk of renal impairment, Other NSAIDs.
Side Effects/ Adverse Reactions (2)	Seizures, Hypoglycemia.	Pulmonary edema, Hypernatremia.	Hypertension, Abdominal bloating.	Hypertension, bronchitis.	Seizures, GI bleeding.
Nursing Considerations (2)	Monitor blood glucose level and adjust	Assess fluid balance (intake and output, daily	Client's renal function	Prolonged effect of long-acting	Be aware that NSAIDs

	<p>insulin dosage as needed, Monitor patient carefully for hypo/hyperglycemia.</p>	<p>weight, edema, lung sounds) throughout therapy. Monitor serum osmolality in patients receiving hypertonic saline solutions.</p>	<p>needs to be tested annually and before therapy, Monitor patient's glucose level regularly to evaluate effectiveness of drug.</p>	<p>insulin may delay recovery from hypoglycemia. Periodically measure HbA1C levels.</p>	<p>should be avoided in patients with a recent MI because of the risk of increased NSAID therapy, Monitor liver enzymes as ordered.</p>
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Medications Reference (APA):

Drugs.com. (2020). *One A Day Women's: Indications, Side Effects, Warnings*

<https://www.drugs.com/cdi/one-a-day-women-s.html>.

Jones & Bartless Learning. (2020). *2020 Nurse's drug handbook (19th ed.)*. Burlington, MA.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alert and oriented X4 Client appeared anxious and fatigued. Overall appearance is normal (well groomed), but did have bags under eyes.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin is dry and intact. White color (slightly pale). Skin is warm. Normal turgor: 2+ No rashes. No bruises. No wounds. Braden score: 23. No drains present.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Clients head is symmetrical (midline with no deviations). Hair is blonde, no patches or balding. Ears are clear and pink. No drainage. Tympanic membrane is visible, pearly grey. PEERLA is present. No nasal deviation (turbinate's equal bilaterally). Oral mucosa is pink and moist (no abnormalities). Teeth present and in good condition.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Normal sinus rhythm noted. S1 & S2 are present. Radial and pedal pulses palpable. No peripheral edema. Normal capillary refill: less than 3 seconds. Client is on telemetry.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Breath sounds are normal and unlabored. Clear breath sounds bilaterally.</p>

<p>Breath Sounds: Location, character</p>	<p>96% oxygen on room air.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Client has a normal diet at home. Height: 5ft 2in. Weight: 165 pounds.</p> <p>Normoactive bowel sounds in all four quadrants. Last BM was yesterday morning. No abnormal masses (enlarged organs) noted. Client was in abdominal pain. No distension. No incisions. No scars. No drains. No wounds.</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Light colored. Clear. Client is urinating frequently (dumped 700 CC of urine). No pain with urination.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>.Active ROM bilaterally. Client ambulates to the bathroom with one assist and feels dizzy doing so. Does not use supportive devices.</p> <p>Fall score: 15 Client needs standby assist due to dizziness.</p>
<p>NEUROLOGICAL (2 points):</p>	<p>.Clients grip strength is equal bilaterally in upper</p>

<p>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>and lower extremities. Client is oriented. Mental status is normal. Speech is clear and normal. No LOC. Client does wear glasses.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>.Client is Christian. Client is developed and has a high school diploma. Client lives with husband and 2 sons. Has family structure and support. Client is mature.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
08:00	72	140/88	22	97.6	96% RA
12:00	76	130/86	20	98.0	97% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
08:00	0-10	Abdomen	8/10	Aching (nausea/vomiting)	Pain medication.
12:00	0-10	Abdomen	3/10	Aching—slightly.	Pain medication PRN.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
<p>Size of IV: Location of IV: Date on IV:</p>	<p>20 Gauge. Left forearm. 11-19-20</p>

Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	0.9% sodium chloride @ 100 ml / hr. No signs of redness, drainage, or swelling.
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Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Client ate 50% of breakfast. Drank 340 CC of water & orange juice.	700 cc of light colored urine.

Nursing Care

Summary of Care (2 points)

Overview of care: Client is receiving 0.9% sodium chloride at 100 ml/hr, insulin Sub-Q, and pain medication as needed IV push. The client came in with abdominal pain rated 8/10 and after toradol, the pain level was 3/10. The client has a new diagnosis of type II diabetes.

Procedures/testing done: The client had a CT scan of her abdomen (results were normal), an A1C—result was 12.8%, and a blood glucose of 601. The client also had an ECG which was normal.

Complaints/Issues: The client is complaining of nausea, vomiting, fatigue, headaches, frequent urination, excessive thirst, and dizziness with walking.

Vital signs (stable/unstable): Stable vital signs.

Tolerating diet, activity, etc.: Client is tolerating diet, but gets dizzy with activity.

Physician notifications: Patient needs diabetes teaching.

Future plans for patient: The client is going to manage her diabetes.

Discharge planning (2 points)

Discharge location: Home with her husband and 2 sons.

Home health needs (if applicable): No home health needs.

Equipment needs (if applicable): No equipment needs.

Follow up plan: The client needs to consult a diabetic educator, and needs to set up diabetic services for outpatient support.

Education needs: The client needs education on insulin and glucose monitoring, signs and symptoms of hyper and hypoglycemia, nutrition education, the supplies needed, and new medication side effects.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis <ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components 	Rational <ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <ul style="list-style-type: none"> How did the patient/family respond to the nurse’s actions? Client response, status of goals and outcomes, modifications to plan.
1. Risk for unstable blood glucose related to type II diabetes as evidence by elevated blood glucose levels.	The client came into the ED with a glucose level of 560 by finger stick.	1. Administer insulin. 2. Assess for hyper or hypoglycemia and treat.	Goal: Lower blood glucose. Outcome: client was willing to accept treatment, and blood glucose levels lowered. Goal: Treat adverse effects (hyper or hypoglycemia). Outcome:

			Hyperglycemia was treated, fluids ran, meds were administered.
1. Deficient knowledge related to diabetes as evidence by elevated blood glucose levels and feeling ill.	Client came into the ED with type II diabetes symptoms for the past month and just now seeking treatment.	1. Teach client about diagnosis. 2. Verify the clients understanding of the disease and interventions she will need to do daily.	Goal: Minimize complications by teaching the client on her new diagnosis. Outcome: client and husband were willing to learn about her new diagnosis. Client understood the basics and what she now needs to do to remain healthy. She repeated back to me what she needed to do so I could verify that she understood her diagnosis and interventions.
1. Fatigue related to diabetes as evidence by fatigue and dizziness upon ambulation.	The client complained of excessive fatigue that has lasted the past month and gets dizzy when she walks.	1. Alternate activity with rest periods and sleep. 2. Discuss ways of conserving energy while ambulating or activity.	Goal: Improve the patient's activity level and have her be able to verbalize an increased energy level. Outcome: Client was willing to follow these interventions to improve her activity and lower her fatigue level.

Other References (APA):

Vera, M. (2020, November 21). *Diabetes Mellitus Nursing Care Plans: 17 Nursing Diagnosis.*

Nurseslabs. <https://nurseslabs.com/diabetes-mellitus-nursing-care-plans/10/>.

Concept Map (20 Points):

Subjective Data

Client stated: "She has been fatigued for the past month".
"She has stomach pain and experiencing nausea and vomiting".
"Has been urinating frequently and has had excessive thirst".
The client states that she does not drink but does smoke a few cigarettes daily.

Nursing Diagnosis/Outcomes

1. Risk for unstable blood glucose related to type II diabetes as evidence by elevated blood glucose levels. Goals: Lower blood glucose levels and Treat adverse effects (hyper or hypoglycemia). Outcomes: client was willing to accept treatment, and blood glucose levels lowered. Hyperglycemia was treated, fluids ran, meds were administered.
2. Deficient knowledge related to diabetes as evidence by elevated blood glucose levels and feeling ill. Goal: Minimize complications by teaching the client on her new diagnosis. Outcome: client and husband were willing to learn about her new diagnosis. Client understood the basics and what she now needs to do to remain healthy. She repeated back to me what she needed to do so I could verify that she understood her diagnosis and interventions.
3. Fatigue related to diabetes as evidence by fatigue and dizziness upon ambulation. Goal: Improve the patient's activity level and have her be able to verbalize an increased energy level. Outcome: Client was willing to follow these interventions to improve her activity and lower her fatigue level.

Objective Data

The client is pale with dark bags under her eyes.
Vital signs:
RR: 20
HR: 76
BP: 130/86
O2: 97% on room air
Temp: 98.0
Pain 3/10 after pain medication.

Patient Information

Client is a 30 year old female who was admitted to the ED on 11-19-20 because of stomach pain, nausea/vomiting, increased thirst, increased urination, fatigue, and dizziness over the past month.
Full code.
No Known allergies.
New diagnosis of Type II diabetes.

Nursing Interventions

1. Administer insulin, Assess for hyper or hypoglycemia and treat.
 2. Teach client about diagnosis and verify the clients understanding of the disease and interventions she will need to do daily.
 3. Alternate activity with rest periods and sleep.
- 2Discuss ways of conserving energy while ambulating or activity.

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