

Diabetes Mellitus Type I/DKA

UNFOLDING Reasoning



Jack Anderson, 9 years old

Primary Concept		
Glucose Regulation		
Interrelated Concepts (In order of emphasis)		
<ul style="list-style-type: none"> • Fluid and Electrolyte Balance • Acid-Base Balance • Clinical Judgment • Patient Education • Communication • Collaboration 		
NCLEX Client Need Categories	Percentage of Items from Each Category/Subcategory	Covered in Case Study
Safe and Effective Care Environment		
✓ Management of Care	17-23%	✓
✓ Safety and Infection Control	9-15%	

Health Promotion and Maintenance	6-12%	✓
Psychosocial Integrity	6-12%	✓
Physiological Integrity		
✓ Basic Care and Comfort	6-12%	✓
✓ Pharmacological and Parenteral Therapies	12-18%	✓
✓ Reduction of Risk Potential	9-15%	✓
✓ Physiological Adaptation	11-17%	✓

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History of Present Problem:

Jack Anderson is a 9-year-old boy who presents to the emergency department because he has been more sleepy and his breathing is “not normal;” it is deeper and faster, according to his parents. Jack was sick with a respiratory virus two weeks ago but has since recovered. Jack began feeling more tired a few days ago when he started to complain of abdominal pain, headache, muscle aches, and consistently being hungry and thirsty. He is urinating more frequently during the day and at night. His mother reports a normal full-term pregnancy and Jack has been healthy with no known medical conditions.

Personal/Social History:

Jack lives with both parents and two siblings; a younger sister four years old and a 12-year-old brother. Both parents work as middle school teachers in the community. Jack is in the 4th grade and earns above-average marks. He is physically active and plays soccer on the school team.

What data from the histories are RELEVANT and must be interpreted as clinically significant by the nurse? (NCSEB: Step 1 Recognize cues/NCLEX Reduction of Risk Potential Reduction of Risk Potential)

RELEVANT Data from Present Problem:	Clinical Significance:
The client has felt “more sleepy” and not breathing normally (deeper and faster). The client has not recovered from a respiratory virus form two weeks ago. Complains of abdominal pain, headache, muscle aches, and consistently being hungry and thirsty. Urinates more frequently, both day and night.	The client is showing signs and symptoms of Type 1 Diabetes Mellitus.
RELEVANT Data from Social History:	Clinical Significance:

Lives with their family	Someone in the family could have passed an illness to the client to cause the client's infection.
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Patient Care Begins:

Current VS:	P-Q-R-S-T Pain Assessment:	
T: 100.4 F/38.0 C (oral)	Provoking/Palliative:	Made worse with solid food.
P: 136 (regular)	Quality:	Dull and aching
R: 44 (deep/rapid)	Region/Radiation:	Confined to abdomen, generalized within abdominal region
BP: 80/48	Severity:	He states his pain is a 4/10 on the numeric scale.
O2 sat: 98% on RA	Timing:	States, "All the time"
Weight: 64.0 lbs/29.1 kg		

What VS data are RELEVANT and must be interpreted as clinically significant by the nurse? (NCSBN: Step 1 Recognize cues/NCLEX Reduction of Risk Potential Reduction of Risk Potential/Health Promotion and Maintenance)

RELEVANT VS Data:	Clinical Significance:
Temp: 100.4 F R: 44 (deep/rapid) BP: 80/48 Pain	The client's temperature is elevated, which could mean an infection. Their respirations are significantly elevated. Their blood pressure is on the lower end. The client has consistent pain in the abdominal region and rates it a 4/10.

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Current Assessment:	
GENERAL SURVEY:	Lying on the bed with eyes closed, whimpers with touch , recognizes mom and dad. Fruity odor to the breath.
NEUROLOGICAL:	Lethargic, responding to parents with one-word phrases. Alert & oriented to person, place, time, and situation (x4); muscle strength 5/5 in both upper and lower extremities bilaterally.
HEENT:	Head normocephalic with symmetry of all facial features. PERRLA, sclera white bilaterally, conjunctival sac pink bilaterally. Eyes appear "sunken," mucus membranes dry, tacky mucosa, chapped lips.
RESPIRATORY:	Breath sounds clear with equal aeration on inspiration and expiration in all lobes anteriorly, posteriorly, and laterally, respirations are deep and rapid

CARDIAC:	Pink, warm & dry, no edema, heart sounds regular, pulses slightly weak/thready , equal with palpation at radial/pedal/post-tibial landmarks, cap refill 2 seconds. Heart tones audible and regular, S1 and S2, noted over A-P-T-M cardiac landmarks with no abnormal beats or murmurs.
ABDOMEN:	Abdomen round, soft, and tender to light palpation . BS active in all four quadrants, feeling nauseated
GU:	Voiding large amounts of clear light yellow urine
INTEGUMENTARY:	Skin warm, dry, itchy, flushed , intact, normal color for ethnicity. No clubbing of nails, cap refill <3 seconds, Hair soft-distribution normal for age and gender. Skin integrity intact, skin turgor nonelastic, tenting present .

What assessment data is RELEVANT and must be interpreted as clinically significant by the nurse? (NCSBN: Step 1 Recognize cues/NCLEX Reduction of Risk Potential Reduction of Risk Potential/Health Promotion & Maintenance)

RELEVANT Assessment Data:	Clinical Significance:
<p>General Survey: fruity odor, whimpers to touch</p> <p>Neuro: lethargic, 1-word phrases</p> <p>HEENT: sunken eyes, dry membranes</p> <p>Respiratory: Deep and rapid RR</p> <p>Cardiac: weak, thready pulses</p> <p>Abdomen: tender to light palpation, nauseous</p> <p>GU: voiding large amounts</p> <p>Skin: itchy, flushed; nonelastic turgor</p>	<p>GS: the fruity breath odor is a significant sign of diabetes mellitus. Whimpering to the touch could be from the pain the client is experiencing.</p> <p>Neuro: The client is lethargic due to imbalances in blood sugar levels within the body.</p> <p>HEENT: the sunken eyes and dry membranes are likely due to dehydration from frequent urination.</p> <p>Respiratory: The deep and rapid respirations, also known as Kussmaul breathing, which indicates diabetic ketoacidosis.</p> <p>Cardiac: The weak, thready pulses are likely due to dehydration.</p> <p>Abdomen: gastrointestinal issues can arise in clients with diabetes.</p> <p>GU: excess glucose in the blood causes the kidneys to overwork, leading to more frequent urination.</p> <p>Skin: itchy skin is typically related to diabetes. The nonelastic skin turgor is likely due to dehydration from frequent urination.</p>

Based on the clinical cues collected so far by the nurse, what additional data is needed ASAP to determine the most likely problem and identify the nursing priority? What orders should the nurse anticipate?

Additional Clinical Data Needed:	Orders to Anticipate:
<p>Blood Glucose level</p> <p>BMP</p>	<p>BMP to determine blood glucose level and kidney function.</p>

Lab Results:

Complete Blood Count (CBC)					
	WBC	HGB	PLTs	% Neuts	Bands
Current:	6.2	16.1	252	58	0
Most Recent:	7.2	14.2	210	52	0

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What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

(NCSBN: Step 1 Recognize cues/NCLEX Reduction of Risk Potential Reduction of Risk Potential/Physiologic Adaptation)

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:
Each of the labs from the CBC are within normal ranges.	Within normal ranges	The WBC count is increasing but is still within normal ranges; could be due to the infection. The nurse should keep an eye on it.

Basic Metabolic Panel (BMP)					
	Na	K	Gluc.	Creat.	CO2 (Bicarb)
Current:	130	5.5	680	1.4	16
Most Recent:	138	4.1	118	0.7	22

What lab results are RELEVANT and must be recognized as clinically significant by the nurse? (NCSBN:

Step 1 Recognize cues/NCLEX Reduction of Risk Potential Reduction of Risk Potential/Physiologic Adaptation)

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:
Na, K, Glucose, Creatinine, CO2	Sodium and Potassium are off due to excessive urination and dehydration. Creatinine and Bicarbonate can be linked to the same thing, and having too much glucose in the bloodstream, causing the kidneys to overwork.	Each of the labs listed above are worsening.

Misc.

	Magnesium	Phosphorus	Beta hydroxybutyrate		
Current:	2.4	2.8	Positive		

What lab results are RELEVANT and must be recognized as clinically significant by the nurse? (NCSBN: Step 1 Recognize cues/NCLEX Reduction of Risk Potential Reduction of Risk Potential/Physiologic Adaptation)

RELEVANT Lab(s):	Clinical Significance:
Mag, Beta-hydroxybutyrate	The magnesium can be thrown off from excessive urination and dehydration. The Beta-hydroxybutyrate test is used to diagnose diabetic ketoacidosis, which is positive and has also been indicated by the breathing patterns of the client (deep and rapid respirations)

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Urinalysis + UA Micro												
	Color:	Clarity:	Sp. Gr.	Protein	Gluc.	Ket.	Nitr.	LET	RBCs	WBCs	Bact.	Epi.
Current:	Lt. yellow	Clear	1.015	Neg	4+	4+	Neg	Neg	0	3	None	none

What lab results are RELEVANT and must be recognized as clinically significant by the nurse? (NCSBN: Step 1 Recognize cues/NCLEX Reduction of Risk Potential Reduction of Risk Potential/Physiologic Adaptation)

RELEVANT Lab(s):	Clinical Significance:
Glucose, Ketones	Both the glucose and ketones within the urine are indicative of diabetes.

Lab Planning: Creating a Plan of Care with a PRIORITY Lab:

(Reduction of Risk Potential/Physiologic Adaptation)

Lab:	Normal Value: 3.5-5.1	Clinical Significance:	Nursing Assessments/Interventions Required:
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Potassium Value: 5.5	Critical Value: 5.5	Can cause dysrhythmias, muscle weakness, or paralysis	Telemetry to monitor heart patterns. Administration of insulin or calcium to balance potassium levels/ bring back to normal range
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Lab:	Normal Value: 70-99	Clinical Significance:	Nursing Assessments/Interventions Required:
Glucose Value: 680	Critical Value: 400	Levels above the critical value indicate diabetic ketoacidosis	Administer insulin, hang fluids/electrolytes (0.9 to get fluid back into cells)

Clinical Reasoning Begins...

1. *Interpreting relevant clinical data, what is the primary problem(s)? What primary health-related concepts does this primary problem represent?* (NCSBN: Step 2 Analyze cues/NCSBN: Step 3 Prioritize hypotheses Management of Care/Physiologic Adaptation)

Problem(s):	Pathophysiology of Problem in OWN Words:	Primary Concept:
Diabetic ketoacidosis	The body metabolizes other energy sources instead of glucose, leading to the liver breaking down fat and causing an excessive buildup of ketones within the body.	Type 1 DM, buildup of ketones

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2. *Is this patient at risk for a change in status that could lead to an adverse outcome due to age, susceptible host, or other factors?* (NCSBN: Step 2 Analyze cues/Management of Care)

Risk Factors for Developing Complication:	Rationale:
Uncontrolled type 1 diabetes mellitus, being sick and not managing blood sugar levels	Both cause glucose imbalances and lead to the body looking for different energy sources (break down fat into ketones) and leads to DKA

3. *What is the worst possible/most likely complication(s) to anticipate based on the primary problem of this patient?* (NCSBN: Step 2 Analyze cues/Reduction of Risk Potential/Physiologic Adaptation)

Worst Possible/Most Likely Complication to Anticipate:	Death/Kidney damage, electrolyte imbalance	
Nursing Interventions to	Assessments to Identify	Nursing Interventions to Rescue:

PREVENT this Complication:	Problem EARLY:	
Administer insulin, hang fluids/electrolytes with 0.9 to get fluid back into the cells. Place an IV to have easy access to administer fluids/electrolytes/medications needed.	BMP, CBC – get glucose level from this S/S the client is displaying (increase in urination frequency)	Fast-acting insulin injection Hang fluids/electrolytes

Collaborative Care: Medical Management

4. State the rationale and expected outcomes for the medical plan of care. (Pharm. and Parenteral Therapies)

Care Provider Orders:	Rationale:	Expected Outcome:
Establish two large bore peripheral IVs	Have access to bloodstream if needed; run fluids	The client will use both IVs to run NS & insulin infusion
Admit to the Pediatric ICU	Be monitored by nurses that specialize in children	The client will get the attention they need from a Pediatric ICU nurse
NPO	Observe for changes that indicate an emergency	Vitals will be monitored frequently and stay stable
Vital signs every 30 minutes with neurological checks every hour	Elevated potassium levels can cause dysrhythmias	No dysrhythmias on telemetry
Continuous cardiac monitor	Monitor blood glucose levels so insulin can be administered accordingly	Glucose levels will be controlled
STAT fingerstick for blood glucose then every one hour	Get fluid back into the cells/counteract dehydration	NS bolus = no S/S of dehydration
Administer NS 20 mL/kg IV BOLUS (over one hour) then begin ½ NS with 20 mEq KCL at maintenance rate (1,000 mL for first 10 kg + 500 mL for next 10 kg over 24 hours)	Infuse insulin to get blood glucose levels under control and maintain a normal level	The client will show normal blood glucose levels
After fluid bolus start IV Regular insulin infusion at 0.05unit/kg/hour Once blood glucose level is less than 300 mg/dL or the blood glucose fall is more than 100 mg/dL, change IV fluids above to Dextrose 5%		

in 0.45 NaCl		
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<p>with 20 mEq KCL</p> <p>Strict I &O and daily weight</p> <p>Ondansetron 2 mg/mL IV push prn every 4 hours nausea</p> <p>Acetaminophen suppository per rectum 350 mg PRN every 4 hours comfort or temp > 38.5 C (>101.3 F)</p>	<p>I/O & daily weight monitoring to determine urine output and fluid balance</p>	<p>I/O will be balanced and daily weight will remain unchanged or improve</p>
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PRIORITY Setting:

5. Which Orders Do You Implement First and Why? (Management of Care)

Care Provider Orders:	Order of Priority:	Rationale:
<ul style="list-style-type: none"> Obtain finger stick blood glucose Start IV insulin after bolus is given and monitor blood glucose carefully Obtain VS Accurate I and O Place on a cardiac monitor Initiate two large bore IVs and administer fluid bolus followed by maintenance/replacement 	<ul style="list-style-type: none"> Initiate two large bore IVs and administer fluid bolus followed by maintenance/replacement Obtain finger stick blood glucose Start IV insulin after bolus is given and monitor blood glucose carefully Obtain VS Place on a cardiac monitor Accurate I and O 	<ol style="list-style-type: none"> Get the IVs going so fluids can be administered Check the blood glucose level to determine how much insulin to give Give the insulin bolus after blood glucose level is determined Vital signs are important, but other things need to be done first Place the client on the cardiac monitor to observe for dysrhythmias begin accurate I/O measurements to determine urine output/signs of dehydration

Collaborative Care: Nursing

6. What nursing priority (ies) will guide your plan of care? (NCSBN: Step 4 Generate solutions/Step 5: Take action Management of Care)

Nursing PRIORITY:	Manage blood glucose levels
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PRIORITY Nursing Interventions:	Rationale:	Expected Outcome:
Blood glucose finger stick IV insulin bolus Balance electrolytes	Determine the client's blood glucose level to administer the proper amount of insulin The client is currently dehydrated, so electrolytes must be given to bring the levels back up	The client will receive the insulin and their blood glucose level will be lower on the next measurement' electrolytes will also get better

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7. What body system(s) will you assess most thoroughly based on the primary/priority concern?

(Reduction of Risk Potential/Physiologic Adaptation)

PRIORITY Body System:	PRIORITY Nursing Assessments:
Circulatory (blood glucose test) Respiratory Cardiac	Finger stick to measure blood glucose levels Assess respirations to determine if the client is still experiencing diabetic ketoacidosis (Kussmaul respirations – deep and rapid breathing) Heart could go in to dysrhythmias d/t potassium imbalance

8. What psychosocial/holistic care PRIORITIES need to be addressed for this patient?

(Psychosocial Integrity/Basic Care and Comfort)

Psychosocial PRIORITIES:	Having parents in the room for comfort	
PRIORITY Nursing Interventions:	Rationale:	Expected Outcome:
CARE/COMFORT: The client needs to have their parents with them due to their age and having a sense of comfort in a new place	The client is in a new place experiencing something painful and new to them, so having their parents with them can be a sense of comfort	The client will be more accepting of things with their parents with them and having their parents' approval
EMOTIONAL (How to develop a therapeutic relationship): Recognize that this is all new to the client and explain thoroughly in a way they will understand	The client is only 9 years old and may not understand what is going on, so try to explain everything thoroughly and in a way they would understand	The client will understand what is going on

Dosage Calculations

- Weight 64 lbs. Convert to kg: **29.1 kgs**
- Administer 0.9% NS 20 mL/kg bolus over one hour. Calculate IV bolus: **582 mL IV bolus**
- Administer regular insulin infusion at 0.05 units/kg/hour. Calculate units/hour: **1.5 units/hour**
- Regular insulin IV is 250 units/250 mL 0.9% NS. Calculate hourly IV drip rate: **1.5 mL/hour**

Evaluation: Four hours later...

Evaluate the response of your patient to nursing and medical interventions during your shift. All physician orders have been implemented that are listed under medical management.

Jack has been transferred from the ED to pediatric ICU two hours ago. His blood glucose is now 442 (this is an appropriate value based on the average of 50-75 mg/dL/hour correction). His insulin gtt is infusing at 1.5 units/hour. You just collected the following clinical data:

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Current VS:	Admission (4 hours):	Current PQRST:	
T: 98.9 F/37.2 C (oral)	T: 100.4 F/38.0 C (oral)	Provoking/Palliative:	
P: 92 (reg)	P: 136 (regular)	Quality:	Dull and aching
R: 24 (reg)	R: 44 (deep/rapid)	Region/Radiation:	Confined to abdomen, generalized within abdominal region
BP: 100/60	BP: 80/48	Severity:	2/10 numeric scale
O2 sat: 98% on RA	O2 sat: 98% on RA	Timing:	States "All the time"
Blood Glucose: 442			

Current Assessment:	
GENERAL SURVEY:	Pleasant, in no acute distress, calm, body relaxed, no grimacing, appears to be resting comfortably.
NEUROLOGICAL:	Alert & oriented to person, place, time, and situation (x4); muscle strength 5/5 in both upper and lower extremities bilaterally.
HEENT:	Head normocephalic with symmetry of all facial features. PERRLA, sclera white bilaterally, conjunctival sac pink bilaterally. Lips, tongue, and oral mucosa pink

	and moist.
RESPIRATORY:	Breath sounds clear with equal aeration on inspiration and expiration in all lobes anteriorly, posteriorly, and laterally, nonlabored respiratory effort on room air.
CARDIAC:	Pink, warm & dry, no edema, heart sounds regular, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks, brisk cap refill. Heart tones audible and regular, S1 and S2 noted over A-P-T-M cardiac landmarks with no abnormal beats or murmurs.
ABDOMEN:	Abdomen round, soft, and nontender. BS active in all 4 quadrants
GU:	Voiding without difficulty, urine clear/yellow
INTEGUMENTARY:	Skin warm, dry, intact, normal color for ethnicity. No clubbing of nails, cap refill <3 seconds, Hair soft-distribution normal for age and gender. Skin integrity intact, skin turgor elastic, no tenting present.

1. What data is RELEVANT and must be interpreted as clinically significant by the nurse?

(NCSBN: Step 1 Recognize cues/Reduction of Risk Potential/Health Promotion and Maintenance)

RELEVANT VS Data:	Clinical Significance:	TREND: Improve/Worsening/Stable:
Pain	Client is still uncomfortable	The pain has improved from the first measurement
RELEVANT Assessment Data:	Clinical Significance:	TREND: Improve/Worsening/Stable:
N/A	N/A	All are improving

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2. Has the status improved or not as expected to this point? Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment? *(NCSBN: Step 6 Evaluate outcomes/Management of Care, Physiological Adaptation)*

Evaluation of Current Status:	Modifications to Current Plan of Care:
The client's status has improved	The current plan of care does not need to be modified. After the insulin bolus and fluids were given, the client was to be monitored. The monitoring of the client will continue even as their condition improves.

3. Based on your current evaluation, what are your CURRENT nursing priorities and plan of care?
 (NCSBN: Step 4 Generate solutions/Step 5: Take action/Management of Care)

CURRENT Nursing PRIORITY:	Manage blood glucose levels	
PRIORITY Nursing Interventions:	Rationale:	Expected Outcome:
Finger stick to determine blood glucose level IV fluids	The client is stable in all other aspects of their health, so continue to monitor their glucose levels and watch it return towards the normal range Dehydration – need electrolytes	The blood glucose levels will continue to decline towards the normal range; electrolytes will get with normal ranges

It is now the end of your shift. Effective and concise handoffs are essential to excellent care and, if not done well, can adversely impact the care of this patient. You have done an excellent job to this point; now finish strong and give the following SBAR report to the nurse who will be caring for this patient:

(Management of Care)

S ituation:
Name/age: Jack Anderson, 9 years old BRIEF summary of primary problem: The client came in displaying signs of diabetic ketoacidosis. The client was treated effectively for the problem and is currently being monitored as the blood glucose levels slowly return to normal.
B ackground:
Primary problem/diagnosis: Diabetes Mellitus RELEVANT past medical history: The client reported being sick with a respiratory virus two weeks ago, but has recovered. RELEVANT background data: The client has felt “more sleepy” and not breathing normally (deeper and faster). The client has not recovered from a respiratory virus from two weeks ago. Complains of abdominal pain, headache, muscle aches, and consistently being hungry and thirsty. Urinates more frequently, both day and night.
A ssessment:
Most recent vital signs: Temp - 98.9 F oral; P - 92; R - 24; BP 100/60; O2 - 98% on RA; Pain - 2/10 RELEVANT body system nursing assessment data: N/A

<p>RELEVANT lab values: Blood Glucose – 442</p> <p>TREND of any abnormal clinical data (stable increasing/decreasing): Blood glucose is decreasing towards the normal range</p> <p>How have you advanced the plan of care? The plan of care has been advanced; currently monitoring the client for changes and leading towards discharge</p> <p>Patient response: The client is responding well to interventions</p> <p>INTERPRETATION of current clinical status (stable/unstable/worsening): The client is stable</p>
<p>Recommendation:</p>
<p>Suggestions to advance the plan of care: Continue to monitor the blood glucose levels</p>

Education Priorities/Discharge Planning

What educational/discharge priorities will be needed to develop a teaching plan for this patient and/or family? (Health Promotion and Maintenance)

<p>Education PRIORITY:</p>	
<p>PRIORITY Topics to Teach: Blood glucose level management, S/S of high/low blood sugar and how to manage levels, Educate what is T1DM and how to treat/live with it</p>	<p>Rationale: Control their blood glucose level so DKA doesn't happen again; how to live with and treat type 1 DM</p>

Caring and the “Art” of Nursing

What is the patient likely experiencing/feeling right now in this situation? What can you do to engage yourself with this patient’s experience, and show that he/she matters to you as a person? (Psychosocial Integrity)

What Patient is Experiencing:	How to Engage:
The client is experiencing something new as they have not had a medical issue before.	Inform the client about T1DM and how to manage it; include the parents in the teaching since the client is only 9 years old. Do teach back with both the client and the family to determine if they understand the teaching

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Use Reflection to Develop Clinical Judgment

What did you do well in this case study?	What knowledge deficits did you identify?
I thought I recognized the S/S of DKA well and prioritized the care for the client well.	I was unaware of what beta-hydroxybutyrate was and that it was the gold standard for DKA.
What did you learn?	How will you apply learning caring for future patients?
Beta-hydroxybutyrate is the gold standard for diagnosing DKA; SBAR from my own interpretations	I will continue to learn and develop thought processes around different diseases and how to treat them effectively. Also, I will learn to communicate with clients of varying ages in ways that best fit the client.

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