N311 Care Plan 2

Ava Cothron

Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Merriweather

09/21/2025

Demographics

Date of Admission 09/17/2025	**Client Initials** RM	**Age** 69 y.o.	**Biological Gender** Female
Race/Ethnicity White/Caucasian	**Occupation** Help at Home	**Marital Status** Married	**Allergies** Lisinopril Nubian (nalbuphine Hcl)
Code Status Full Code	**Height** 5’	**Weight** 156lbs	

Medical History

Past Medical History: Past Medical History includes Asthma, Bone Spur, Congestive Heart Failure (CHF) Covid 19 (12/07/2020), Diabetes Mellitus, Diabetic Ketoacidosis (DKA), High Cholesterol, Hypertension, and Lung Nodule

Past Surgical History: Past Surgical History includes Cholecystectomy, Cardiac Surgical Procedure unlisted, and Laparoscopic Appendectomy

Family History: Breast Cancer in Maternal aunt, Congestive Heart Failure in her father, Diabetes in her mother, and Emphysema in her father

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient states she has never smoked, never used smokeless tobacco, she does not use drugs and does not drink alcohol

Education: No education listed in the chart

Living Situation: Patient lives at Home

Assistive devices: None listed in Chart

Admission Assessment

Chief Complaint: Low Blood Sugar

History of Present Illness (HPI) – OLD CARTS: Patient is a 69 y.o. female with a health history of Asthma, Bone Spur, Congestive Heart Failure, Covid 19, Diabetes Mellitus, Diabetic Ketoacidosis, High Cholesterol, Hypertension, and Lung Nodule. Patient presents with Altered Mental Status due to a low blood sugar of 22 with an onset of 1630 9/16/25. Patient location was undetermined to make because patient was unresponsive on arrival. Patient states she started feeling bad the night of 9/16/25 due to turning her insulin pump off because it was not working right. ~~States she was~~ The patient reports feeling very weak and had to call into work. ~~due to feeling so unwell~~. Patient states being up and moving around makes her symptoms worse and laying in bed helps her feel a little better. Husband states he gave her a peanut butter sandwich before calling the ambulance, but it did not seem to make the patient any better. Unable to determine severity due to patient being unresponsive.

Primary Diagnosis

Primary Diagnosis on Admission: Hypoglycemia

Secondary Diagnosis (if applicable): Secondary Diagnosis not applicable

Pathophysiology

Pathophysiology of the Disease, APA format:

Pathophysiology References (2) (APA):

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1250	64 BPM	151/58	16 BPM	97.3 F	98% Room Air

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
1322	0-10	Not Applicable	0	Not Applicable	Not Applicable

Intake and Output

Intake (in mL)	Output (in mL)
75% of lunch 250ml with meal	2 Urine Occurrence (include why urine was not measured)

Nursing Diagnosis
Must be NANDA approved nursing diagnosis

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	Rationale • Explain why the nursing diagnosis was chosen	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for unstable glucose level related to Hypoglycemia as evidenced by patients having low blood sugar levels.	Chosen because patient had low blood sugar readings	1. Assess patients for symptoms of low glucose levels and maintain a patent airway if Indicated 2.Assess for underlying causes of	1. Patient has no episodes of Hypoglycemia	Patient will verbalize understanding of how to control blood glucose level

		changes in glucose		
2. Risk for unstable blood glucose level related to inadequate adherence to treatment regimen as evidenced by patient having low blood glucose levels	Chosen because patient had low blood glucose reading	1. Assess family understanding of prescribed treatment regimen 2.Monitor or instruct patients to monitor glucose levels with a glucometer at regular intervals	1. Patient verbalizes understanding of how to control blood glucose level	Patient verbalizes glucose management plan

Other References (APA):

Gedas Gudenas, J. K. (n.d.). *Nursing diagnosis reference manual. text with access code*. Books. https://www.matthewsbooks.com/productdetail.aspx?pid=9751PHE9895