

N321 Care Plan # 1

Lakeview College of Nursing

Ana Punsalan

**Demographics (3 points)**

<b>Date of Admission</b> 2/12/2020	<b>Patient Initials</b> C.N.	<b>Age</b> 78	<b>Gender</b> Female
<b>Race/Ethnicity</b> African American	<b>Occupation</b> No occupation	<b>Marital Status</b> Single	<b>Allergies</b> Chocolate, Clonidine, Lisinopril, Metformin
<b>Code Status</b> DNR	<b>Height</b> 5'8	<b>Weight</b> 159 lbs.	

**Medical History (5 Points)**

**Past Medical History:** Acute on chronic combined systolic and diastolic congestive heart failure, Arteriosclerotic heart disease, Diabetes mellitus, End-stage renal disease on dialysis, GERD, Hypertension, Hyperlipidemia, Hypothyroidism, Stage 3 chronic kidney disease, Pulmonary embolism, Coronary artery disease, Stroke

**Past Surgical History:** Cesarean section, Appendectomy, Hernia repair, Cholecystectomy, Hysterectomy, Cardia catheterization, Insertion dialysis catheter, Colonoscopy

**Family History:** Renal failure in her brother, paternal uncle, and sister

**Social History (tobacco/alcohol/drugs):** No tobacco, alcohol, or drugs

**Assistive Devices:** Walker, Wheelchair, and a shower seat

**Living Situation:** Patient lives alone in a single-story home.

**Education Level:** High school

**Admission Assessment**

**Chief Complaint (2 points):** Left-sided abdominal pain and intermittent nausea

**History of present Illness (10 points):** Patient complains of left-sided abdominal pain and intermittent nausea. Patient has also been having tremors of the bilateral hands. Patient recently had an EGD done as an outpatient. It was thought that her pain maybe related to constipation. She was given a does of magnesium citrate and had a bowel movement.

**Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** Constipation

**Secondary Diagnosis (if applicable):** N/A

**Pathophysiology of the Disease, APA format (20 points):** SEE NEXT PAGE

**Pathophysiology References (2) (APA):**

Mayo Clinic. (2019, June 29). Constipation. Retrieved from

<https://www.mayoclinic.org/diseases-conditions/constipation/symptoms-causes/syc-20354253>

Sethi, S. (2019, August 23). What you should know about constipation. Retrieved from [https://](https://www.healthline.com/health/constipation)

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## **Constipation**

Chronic constipation is infrequent bowel movements or difficult passage of stools that persists for several weeks or longer. Constipation is generally described as having fewer than three bowel movements a week. Though occasional constipation is very common, some people experience chronic constipation that can interfere with their ability to go about their daily tasks. Chronic constipation may also cause people to strain excessively in order to have a bowel movement.

Signs and symptoms of chronic constipation include: passing fewer than three stools a week, having lumpy or hard stools, straining to have bowel movements, feeling as though there's a blockage in your rectum that prevents bowel movements, and feeling as though you can't completely empty the stool from your rectum, which patient has experienced.

Diagnostic tests and procedures include blood tests, x-ray, sigmoidoscopy, colonoscopy, anorectal manometry, balloon expulsion test, colon transit study, defecography, and an MRI defecography.

Treatment include adding fiber-rich foods to diet, exercising most days of the week, don't ignore the urge to have a bowel movement, adding fiber supplements to diet, using laxatives sparingly, and drink plenty of fluids.

Patient complains of left-sided abdominal pain and intermittent nausea. It was thought that her pain maybe related to constipation. She was given a does of magnesium citrate and had a bowel movement. Patient also had a CT abdomen & pelvis without contrast test done.

## 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	4.40-5.80			
Hgb	13.0-16.5	11.9	N/A	Having stage 3 chronic kidney disease decreased Hgb value.
Hct	38.0-50.0	35.3	N/A	Having stage 3 chronic kidney disease decreased Hct value.
Platelets	140-440	121	N/A	Hemodialysis decreased platelet count.
WBC	4.00-12.00			
Neutrophils	40.0-68.0%			
Lymphocytes	19.0-49%			
Monocytes	3.0-13.0%			
Eosinophils	0.0-8.0%			
Bands	0.0-4.0			

**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 mmol/L			
K+	3.5-5.0 mmol/L			
Cl-	98-108			
CO2	23-29			
Glucose	70-100 mg/dL	107	N/A	Having diabetes increased glucose value.
BUN	8-25 mg/dL	34	N/A	Having stage 3 chronic kidney disease increased BUN value.

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<b>Creatinine</b>	0.6-1.3 mg/dL	5.61	N/A	Having stage 3 chronic kidney disease increased creatinine value.
<b>Albumin</b>	3.5-5.2 gm/dL			
<b>Calcium</b>	8.6-10 mg/dL			
<b>Mag</b>	1.5-2.6			
<b>Phosphate</b>	2.5-4.5			
<b>Bilirubin</b>	<1.5 mg/dL			
<b>Alk Phos</b>	34-104			
<b>AST</b>	10-30 units/L			
<b>ALT</b>	10-40 units/L			
<b>Amylase</b>	23-470			
<b>Lipase</b>	20-86			
<b>Lactic Acid</b>	0.5-1.0			

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

<b>Lab Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>INR</b>	2-3			
<b>PT</b>	F: 9.5-11.3 s M: 9.6-11.8 s			
<b>PTT</b>	30-40 s			
<b>D-Dimer</b>	≤250 ng/mL			
<b>BNP</b>	<125			

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<b>HDL</b>	40-59			
<b>LDL</b>	100-129			
<b>Cholesterol</b>	<200			
<b>Triglycerides</b>	<150			
<b>Hgb A1c</b>	4-5.6%			
<b>TSH</b>	0.4-4.0			

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

<b>Lab Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>Color &amp; Clarity</b>	Ambery yellow clear			
<b>pH</b>	5.0-9.0			
<b>Specific Gravity</b>	1.003-1.030			
<b>Glucose</b>	Negative			
<b>Protein</b>	-0.8 mg/dL			
<b>Ketones</b>	Negative			
<b>WBC</b>	0.4			
<b>RBC</b>	≤2			
<b>Leukoesterase</b>	Negative			

**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
<b>Urine Culture</b>	(-) < 10,000mL (+) > 100,000mL			
<b>Blood Culture</b>	Negative			
<b>Sputum Culture</b>	Normal upper respiratory tract			
<b>Stool Culture</b>	Normal intestinal flora			

**Lab Correlations Reference (APA):**

Pagana, K. D., Pagana, T.J., & Pagana, T.N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14<sup>th</sup> ed). MO; Elsevier.

**All Other Diagnostic Tests (5 points):**

CT abdomen & pelvis without contrast:

Lung bases/thorax: small bilateral pleural effusions

Stomach: post-op changes from gastric surgery

Liver: multiple simple hepatic cyst

Gallbladder: post-op changes from cholecystectomy

Kidneys/ureters: left-sided renal cyst that measures up to 4.5cm size

**Diagnostic Test Correlation (5 points):** Patient complains of left-sided abdominal pain. CT is to help detect diseases of the small bowel, colon and other internal organs and is often used to determine the cause of unexplained pain.

**Diagnostic Test Reference (APA):**

Rogers, G. (2017, July 5). *What is an abdominal CT scan?*. Retrieved from

<https://www.healthline.com/health/abdominal-ct-scan>

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

**\*10 different medications must be completed\***

**Home Medications (5 required)**

<b>Brand/Generic</b>	aspirin (acetylsalicylic acid)	allopurinol (Zyloprim)	amiodarone (Cordarone)	amlodipine (Norvasc)	atorvastatin (Lipitor)
<b>Dose</b>	81 mg	100mg	200mg	5mg	10mg
<b>Frequency</b>	Daily	Daily	BID	Daily	Daily
<b>Route</b>	Oral	Oral	Oral	Oral	Oral
<b>Classification</b>	Nonopioid analgesic	Antigout	Class III antiarrhythmic	Anti-hypertensive	Anti-hyperlipidemic
<b>Mechanism of Action</b>	Subside inflammatory symptoms and pain	Inhibits uric acid production	Improves myocardial blood flow	Decreases myocardial workload	Inhibit cholesterol synthesis
<b>Reason Client Taking</b>	To relieve mild pain	To treat hyperuricemia	To treat recurrent V.fibs and V.tachs	To control hypertension	To control lipid levels
<b>Contraindications (2)</b>	-low levels of vit K -anemia	-dehydration -chronic heart failure	-overactive thyroid gland -liver problems	-severe narrowing of the aortic valve -significantly low BP	-alcoholism -brain hemorrhage
<b>Side Effects/Adverse Reactions (2)</b>	-Excess stomach acid secretion -Heartburn	-Skin rash -Hives	-Trouble with walking -Weakness of arms or legs	-Swelling of ankles or feet -Feeling of warmth	-Unusual tiredness or weakness -fever
<b>Nursing Considerations (2)</b>	-Don't crush tablets. -Advise pt not to drink with ibuprofen.	-Obtain CBC & uric acid level. -Maintain a fluid intake to produce urinary output of 2L daily.	-Assess thyroid hormone levels. -Monitor liver enzymes, as ordered.	-Monitor BP while adjusting dosage. -Assess pt for chest pain.	-Expect liver function tests to be performed. -Monitor diabetic pt's blood glucose.

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	acetaminophen (Tylenol)	apixaban (Eliquis)	losartan (Cozaar)	calcitriol (Rocaltrol)	metoclopramide (Reglan)
<b>Dose</b>	650mg	5mg	25mg	0.5mcg	5mg
<b>Frequency</b>	Q4H	BID	Daily	Daily	BID
<b>Route</b>	Oral	Oral	Oral	Oral	Oral
<b>Classification</b>	Nonopioid analgesic	To reduce risk of stroke	Anti-hypertensive	Anti-hypoparathyroid	Upper GI stimulant
<b>Mechanism of Action</b>	Interfere with pain impulse	Inhibit platelet aggregation	Reduce BP	Increase calcium absorption	Promotes gastric emptying and peristalsis
<b>Reason Client Taking</b>	To relieve mild to moderate pain	To reduce risk of stroke and systemic embolism	To manage hypertension	To treat hypoparathyroidism	To treat gastroesophageal reflux disease
<b>Contraindications (2)</b>	-caloric undernutrition -severe renal impairment	-increased risk of bleeding -kidney disease	-diabetes -high cholesterol	-kidney stones -high amount of calcium in the blood	-depression -high BP
<b>Side Effects/Adverse Reactions (2)</b>	-Rash -Nausea & headache	-Excessive bleeding -diarrhea or constipation	-Backache -Muscle weakness	-Dehydration -High or low calcium levels	-Diarrhea -Drowsiness
<b>Nursing Considerations (2)</b>	-Monitor renal function. -Ensure daily dose does not exceed maximum daily limits.	-Not be given to pts with severe hepatic dysfunction . -Monitor pt closely for bleeding.	-Monitor BP & renal function. -Monitor potassium level for hyperkalemia .	-Check pt receives enough calcium. -Monitor pt closely.	-Assess pt for signs of intestinal obstruction. -May increase catecholamine levels.

**Medications Reference (APA):**

Jones & Bartlett Learning. (2019). *2019 Nurse’s Drug Handbook* (18<sup>th</sup> ed.). Burlington, MA.

**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (1 point):</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p>Appears alert &amp; oriented; No apparent distress; looks her age; Clean; Appears frail &amp; fatigued</p>
<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds:</b>  <b>Braden Score:</b>  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>Skin is within patient's norm          Fair skin; warm &amp; dry; She is not diaphoretic;          Temperature is within average range;          Turgor shows hydration;          No rashes, bruises, wounds;          Braden Score:16</p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>Head &amp; neck are symmetrical; trachea is midline without deviation; Auricle is moist and pink without lesions; sclera is white; conjunctiva is clear; lids are moist &amp; pink; septum is midline; sinuses are nontender; dentition is good</p>
<p><b>CARDIOVASCULAR (2 points):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>Normal rate; S1 &amp; S2 without murmurs, gallops, or rubs; pulses are 2+ throughout; capillary refill less than 2 seconds</p>
<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>Respirations are regular even &amp; nonlabored, symmetrical, no wheezes or crackles noted;</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at home:</b>  <b>Current Diet</b>  <b>Height:</b>  <b>Weight:</b></p>	<p>Eats a regular balanced diet at home;          Currently consumed 100% of lunch;          Height: 5'8          Weight: 159 lbs.</p>

<p><b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>              <b>Distention:</b>              <b>Incisions:</b>              <b>Scars:</b>              <b>Drains:</b>              <b>Wounds:</b>  <b>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>              <b>Size:</b>  <b>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>              <b>Type:</b></p>	<p>Bowel sounds are normoactive.          Last BM: One day ago;          Soft, tenderness (left flank), no mass;          No distention, incisions, scars, drains, or wounds</p>
<p><b>GENITOURINARY (2 Points):</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Dialysis: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Inspection of genitals:</b>  <b>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>              <b>Type:</b>              <b>Size:</b></p>	<p>Patient was in dialysis; did not urinate</p> <p>Genitals appear pink &amp; moist</p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>Neurovascular status:</b>  <b>ROM:</b>  <b>Supportive devices:</b>  <b>Strength:</b>  <b>ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib) <input type="checkbox"/></b>  <b>Needs assistance with equipment <input type="checkbox"/></b>  <b>Needs support to stand and walk <input checked="" type="checkbox"/></b></p>	<p>CV II-XII are intact; Reflexes are 1-2+ throughout; Coordination: Normal finger to nose bilaterally; No pain, paralysis; No paresthesia; Not pallor; Warm temperature; No swelling or increased pressure; Needs supportive devices: walker, wheelchair, and a shower seat; She is independent with her ADLs;          Fall Score: 15</p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -</b>  <b>Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></b>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b></p>	<p>Alert &amp; oriented to person &amp; place; Speech is articulate; Decreased sensation to pinprick in a stocking and glove fashion; No LOC; Judgement &amp; thought content normal</p>

<b>Sensory: LOC:</b>	
<b>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion &amp; what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</b>	Watches TV and naps; Ego integrity, wisdom & the ability to participate in life with a sense of satisfaction; Protestant; has a son and a daughter for support

**Vital Signs, 2 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	73	121/78	18	97 °F	100
1545	72	118/78	18	97.2°F	100

**Pain Assessment, 2 sets (2 points)**

Time	Scale	Location	Severity	Characteristics	Interventions
1300	Numeric	N/A	0/10	N/A	N/A
1545	Numeric	N/A	0/10	N/A	N/A

**IV Assessment (2 Points)**

IV Assessment	Fluid Type/Rate or Saline Lock
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> N/A <b>Patency of IV:</b> N/A <b>Signs of erythema, drainage, etc.:</b> N/A <b>IV dressing assessment:</b> N/A	N/A – Patient did NOT have an IV

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
360mL	0mL

## Nursing Care

### Summary of Care (2 points)

**Overview of care:** Patient didn't complain of any abdominal pain. Patient was cooperative and didn't complain during dialysis.

**Procedures/testing done:** CT abdomen & pelvis without contrast

**Complaints/Issues:** Left-sided abdominal pain & intermittent nausea

**Vital signs (stable/unstable):** Stable

**Tolerating diet, activity, etc.:** Tolerates diet and activities

**Physician notifications:** Keep day-by-day list to track the number, hardness, and pattern of stools.

**Future plans for patient:** Relieve constipation

### Discharge Planning (2 points)

**Discharge location:** To home

**Home health needs (if applicable):** Has caregivers that come 3hrs/day 5days/week.

**Equipment needs (if applicable):** Walker and wheelchair

**Follow up plan:** Abdominal & constipation – continue to give magnesium citrate and monitoring.

**Education needs:** Prevent constipation. Instruct patient to eat a diet that is high in fiber including fresh fruits, vegetables, and whole grains. Drink plenty of water and fruit juices. Exercise regularly or increase activity level. Establish healthy bowel diets. Go to the bathroom when you feel the need to void.

**Nursing Diagnosis (15 points)**

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

<b>Nursing Diagnosis</b>	<b>Rational</b>	<b>Intervention (2 per dx)</b>	<b>Evaluation</b>
<ul style="list-style-type: none"><li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li></ul>	<ul style="list-style-type: none"><li>• Explain why the nursing diagnosis was chosen</li></ul>		<ul style="list-style-type: none"><li>• How did the patient/family respond to the nurse’s actions?</li><li>• Client response, status of goals and outcomes, modifications to plan.</li></ul>

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<p>1. Abdominal pain related to decreased in normal frequency of defecation as evidenced by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool.</p>	<p>Patient's complain was thought to be related to constipation. She was given a dose of magnesium citrate and have a bowel movement.</p>	<ol style="list-style-type: none"> <li>1. Encourage patient to take in fluid 2000-3000 mL/day.</li> <li>2. Encourage a regular period for elimination.</li> </ol>	<p>Patient maintains passage of soft, formed stool at a frequency perceived as "normal" by the patient. Patient states relief from discomfort of constipation.</p>
<p>2. Risk for infection related to invasive catheters and impaired immune function as evidenced by end-stage renal disease on dialysis.</p>	<p>Patient has stage 3 chronic kidney disease.</p>	<ol style="list-style-type: none"> <li>1. Observe and report signs of infections such as redness, warmth, discharge and increased body temperature.</li> <li>2. Assess temperature, respiratory, and urinary system for any signs and symptoms of infection.</li> </ol>	<p>Patient is infection free as evidenced by temperature remaining &lt;99° F, and normal lab values including WBC count, urine and/or blood cultures.</p>
<p>3. Risk for unstable blood glucose level related to diabetes as evidence by high finger-stick blood glucose readings.</p>	<p>Patient has high glucose levels due to diabetes.</p>	<ol style="list-style-type: none"> <li>1. Assess blood glucose before meals and at bedtime.</li> <li>2. Assess for signs of hyperglycemia.</li> </ol>	<p>Patient has a blood glucose reading less than 180mg/dL.</p>

**Other References (APA):**

Swearingen, P. (2016). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (4<sup>th</sup> ed.). Elsevier.

**Concept Map (20 Points):**

### Subjective Data

“Left-sided abdominal pain and intermittent nausea.”

### Nursing Diagnosis/Outcomes

Diagnosis #1 Abdominal pain related to decreased in normal frequency of defecation as evidenced by difficult or incomplete passage of stool and/or passage of excessively hard, dry stool.  
Outcome Patient maintains passage of soft, formed stool at a frequency perceived as “normal” by the patient. Patient states relief from discomfort of constipation.

Diagnosis #2 Risk for infection related to invasive catheters and impaired immune function as evidence by end-stage renal disease on dialysis.  
Outcome Patient will be infection free as evidenced by temperature remaining <99°F, and normal lab values including WBC count, urine and/or blood cultures.

Diagnosis #3 Risk for unstable blood glucose level related to diabetes as evidence by high finger-stick blood glucose readings.  
Outcome Patient has a blood glucose reading less than 180mg/dL.

### Objective Data

Hgb 11.9  
Hct 53.3  
Platelets 121  
Glucose 107  
BUN 34  
Creatinine 5.61  
Pulse 73; 72  
BP 121/78; 118/78  
Resp Rate 18  
Temp 97°F; 97.2°F  
Oxygen 100

### Patient Information

M.N.  
Admitted 2/12/2020  
78 years old  
Female, African American  
No occupation  
Single  
Allergies – Chocolate, Clonidine,  
Lisinopril, Metformin  
Height: 5’8  
Weight: 159 lbs.  
Code: DNR

### Nursing Interventions

Diagnosis #1 Interventions:  
Encourage patient to take in fluid 2000-3000 mL/day.  
Encourage a regular period for elimination.  
Diagnosis #2 Interventions:  
Observe and report signs of infections such as redness, warmth, discharge and increased body temperature.  
Assess temperature, respiratory, and urinary system for any signs and symptoms of infection.  
Diagnosis #3 Interventions:  
Assess blood glucose before meals and at bedtime.  
Assess for signs of hyperglycemia.

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