N441 Care Plan #1

Lakeview College of Nursing

Taniya Varghese

N431 Care Plan

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
03/31/2020	A.T.	18 years old	Female
Race/Ethnicity	Occupation	Marital Status	Allergies
Caucasian	Student	Single	No known Allergies
Code Status	Height	Weight	
Full Code	5’3	125 lbs	

Medical History (5 Points)

Past Medical History: Patient has no known past medical history

Past Surgical History: Patient has no known past surgical history

Family History: N/A

Social History (tobacco/alcohol/drugs): N/A

Assistive Devices: Patient does not use any assistive devices.

Living Situation: Patient lives in Champaign

Education Level: Patient is currently in high school

Admission Assessment

Chief Complaint (2 points): Patient presented to the ED in a lethargic state.

History of present Illness (10 points):.

Angela is an 18 y.o. female with no known past medical or surgical history. According to Angela’s parents, Angela was experiencing excessive thirst, excessive urination and a rapid weight loss. Angela’s weight had significantly dropped in the past month and has gotten worse in

the past week. Angela is not known to take any medications on in the past and she has not been using any alcohol or drug to induce this sudden change of onset. On examination in the emergency room, Angela presents with deep and rapid respirations, her pulse rate was at 100 beats per minute, her blood pressure read at 110/70. She is so very lethargic; her lungs are clear, and her skin is clammy. She is on an EKG monitor and it is reading a normal sinus rhythm. Lastly, she is showing signs of dehydration with symptoms like drowsiness and an altered level of consciousness. A CBC and a chemistry panel was drawn on the patient and it shows a hematocrit 44%, hemoglobin 13 g/dl (140 g/L), white blood cell count 12,000/ µl, glucose 520, BUN 50, creatinine 0.8, Na+ 148 mEq/L, K+ 4.6 mEq/L, PO4 3-2.0 mEq/L, and Cl− 112 mmol/ L. Arterial pH was 7.0, PO 2 98 mmHg, PCO2 25 mmHg, HCO3 12 mEq/L, and O2 sat 98%. An IV has been started and she has received a bolus of 0.9NS of 1L, she now has 0.9NS going at 200/hr. She has been started on an insulin drip at 4u/hr. She is on 2L of nasal cannula and has a diet of NPO ordered and she is to remain on bedrest.

Primary Diagnosis on Admission (2 points): Diabetic Ketoacidosis

Secondary Diagnosis (if applicable):. N/A

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

Diabetic ketoacidosis is a complication that occurs when your body produces a high level of blood acids called ketones. Diabetic ketoacidosis is a complication of diabetes. The condition can begin when the body can’t produce enough insulin. Insulin is found in the body to regulate

glucose. It is vital for glucose, which is a major source for energy in the body especially for your muscles and other tissue like the brain to enter your cells. Nevertheless, when there isn't enough insulin in your cells, the body will break down fat instead of sugar. When fat is broken down, an acid called "ketone" will start to build up in the bloodstream. This will lead to diabetic ketoacidosis. Manifestations of diabetic ketoacidosis develop quickly and sometimes within the first 24 hours. Patients may experience excessive thirst, frequent urination, nausea, vomiting, abdominal pain, weakness, fatigue, shortness of breath, fruity – scented breath, and confusion. There specific at manifestations that can be indicated in a at home urine testing kits. If diabetic ketoacidosis is suspected, the test will show hyperglycemia, and a high ketone level in the urine. Diabetic ketoacidosis is usually triggered by an infection or an illness. Higher levels of cortisol or adrenaline can affect insulin and trigger DKA. Infections like pneumonia and urinary tract infects can also trigger DKA. Another cause of DKA can be issues with insulin therapy such as missing a dose which can lead to too little insulin. Other triggers like physical or emotional trauma, heart attack, alcohol or drug abuse, and certain medications like corticosteroids or diuretics (Mayo Clinic, 2019). It is important to know the ways that one can prevent DKA and other diabetic complications. The most important way to prevent exacerbation is to commit to a lifestyle that manages the diabetes. This will include eating healthy and making time for physical activities. Patients should be aware of how they can monitor their blood sugar level and how they can adjust their insulin as needed. Along with knowing your blood sugar levels, a patient should

know how to check ketone levels. Ketones in the urine will let the patient know what stage they are at and if they need to take more insulin. Diagnostic exams that can be done to make sure the patient is in DKA are blood tests that will look for blood sugar level, ketone level, blood acidity. Other exams are urinalysis, chest x-ray, and an ECG to measure electrical activity in the heart (Van Leeuwen & Bladh, 2017). Lastly, treatment for DKA will include fluid replacement. Fluid is given to replace the amount of fluid lost through excessive urination and it will help to dilute the excess sugar in the blood. The patient will also have insulin therapy. This is done to reverse the acidity of the blood. When blood levels reach about 200 mg/dL the patient's blood is no longer acidic. At this point the IV insulin therapy will be stopped and the patient can resume normal subcutaneous insulin therapy. Overall, DKA is a condition that needs fast planning and the right treatment. It is vital patients know how to implement preventative measures as well as treatment.

Pathophysiology References (2) (APA):

Mayo Clinic. (2019, December 11). Diabetic Ketoacidosis. Retrieved from https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A.

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Davis Company.

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	**3.8-5.3 x10^6**	**N/A**	**na**	
Hgb	**12.0-15.8**	**N/A**	**13**	Hemoglobin levels are unstable due to patient experiencing dehydration. (Van Leeuwen & Bladh, 2017, p. 496)
Hct	**36.0-47.0%**	**N/A**	**44%**	Hematocrit levels are unstable due to patient experiencing dehydration. (Van Leeuwen & Bladh, 2017, p. 496)
Platelets	**140-440 x10^3**	**N/A**	**na**	
WBC	**4.00-12.00 x10^3**	**N/A**	**12.00**	
Neutrophils	**47.0-73.0%**	**N/A**	**na**	
Lymphocytes	**18.0-42.0%**	**N/A**	**na**	
Monocytes	**4.0-12.0%**	**N/A**	**na**	
Eosinophils	**0.0-5.0%**	**N/A**	**na**	
Bands	**na**	**N/A**	**na**	

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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-	**133-144**	**N/A**	**148**	Elevated sodium levels because patient is dehydrated. (Van Leeuwen & Bladh, 2017, p. 496)
K+	**3.5-5.1**	**N/A**	**4.6**	
Cl-	**98-107**	**N/A**	**112**	Elevated chloride levels because patient is dehydrated. (Van Leeuwen & Bladh, 2017, p. 496)
CO2	**21-31**	**N/A**	**26**	
Glucose	**70-99**	**N/A**	**520**	Elevated glucose levels because patient is in DKA. (Van Leeuwen & Bladh, 2017, p. 496)
BUN	**7-25**	**N/A**	**50**	Elevated BUN levels because patient is dehydrated. (Van Leeuwen & Bladh, 2017, p. 496)
Creatinine	**0.5-1.20**	**N/A**	**.8**	
Albumin	**3.5-5.7**	**N/A**	**na**	
Calcium	**8.6-10.3**	**N/A**	**na**	

Mag	**1.6-2.6**	**N/A**	**na**	
Phosphate		**N/A**	**na**	
Bilirubin	**0.2-0.8**	**N/A**	**na**	
Alk Phos	**34-104**	**N/A**	**na**	
AST	**13-39**	**N/A**	**na**	
ALT	**7-52**	**N/A**	**na**	
Amylase		**N/A**	**na**	
Lipase	**11-82**	**N/A**	**na**	
Lactic Acid	**0.5-2.0**	**N/A**	**N/A**	
Troponin	**0 - 0.4**	**N/A**	**N/A**	
CK-MB	**N/A**	**N/A**	**N/A**	
Total CK	**N/A**	**N/A**	**N/A**	

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	**N/A**	**N/A**	**N/A**	

PT	**N/A**	**N/A**	**N/A**	
PTT	**N/A**	**N/A**	**N/A**	
D-Dimer	**N/A**	**N/A**	**N/A**	
BNP	**N/A**	**N/A**	**N/A**	
HDL	**50-200mg/dl**	**N/A**	**na**	
LDL	**70-130mg/ dL**	**N/A**	**na**	
Cholesterol	**N/A**	**N/A**	**N/A**	
Triglycerides	**N/A**	**N/A**	**N/A**	
Hgb A1c	**N/A**	**N/A**	**N/A**	
TSH	**N/A**	**N/A**	**N/A**	

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
Color & Clarity	**N/A**	**N/A**	**N/A**	
pH	**N/**	**N/A**	**N/A**	
Specific Gravity	**N/A**	**N/A**	**N/A**	
Glucose	**N/A**	**N/A**	**N/A**	
Protein	**N/A**	**N/A**	**N/A**	
Ketones	**N/A**	**N/A**	**N/A**	

WBC	**N/A**	**N/A**	**N/A**	
RBC	**N/A**	**N/A**	**N/A**	
Leukoesterase	**N/A**	**N/A**	**N/A**	

Arterial Blood Gas 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
pH	**7.35 – 7.45**	**N/A**	**7.0**	pH levels are low because patient is experiencing Metabolic acidosis. Van Leeuwen & Bladh, 2017, p. 496)
PaO2	**90 - 100**	**N/A**	**98**	
PaCO2	**22-26**	**N/A**	**25**	
HCO3	**35-45**	**N/A**	**12**	Bicarb levels are low because patient is experiencing Metabolic acidosis. Van Leeuwen & Bladh, 2017, p. 496)
SaO2	**N/A**	**N/A**	**98%**	

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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	**N/A**	**N/A**	**N/A**	
Blood Culture	**N/A**	**N/A**	**N/A**	
Sputum Culture	**N/A**	**N/A**	**N/A**	
Stool Culture	**N/A**	**N/A**	**N/A**	

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points): EKG , CBC, Urine analysis

Diagnostic Test Correlation (5 points):

This patient had a Chest Xray done to gain a better image of the chest. A chest x ray uses electromagnetic waves to create images of the chest and the structures around the chest. A chest

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x ray is a helpful diagnostic tool in patients with conditions like pneumonia , heart failure, lung cancer, tuberculosis and even lung tissue scarring.

Diagnostic Test Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Acetaminophen/ Tylenol
Dose	650 mg
Frequency	Once daily
Route	PO
Classification	Antipyretic
Mechanism of Action	To relieve mild to moderate pain
Reason Client Taking	Pain due to abdominal pain
Contraindications (2)	Hepatic impairment Liver Disease
Side Effects/Adverse	Fatigue

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Reactions (2)	Stridor
Nursing Considerations (2)	Monitor at the end of parenteral infusion Monitor renal function in pt with long term therapy
Key Nursing Assessment(s)/Lab(s) Prior to Administration	AST, ALT , creatine
Client Teaching needs (2)	May be crushed or chewed Caution Pt. not to exceed the recommended dose

Hospital Medications (5 required)

Brand/Generic	Sodium Chloride	Insulin Regular	Sodium Bicarbonate
Dose	0.9% NaCl	4u/hr	N/A
Frequency	PRN	PRN	PRN
Route	IV	IV	IV
Classification	Mineral and electrolyte replacement	Antidiabetics	Antiulcer agent
Mechanism of Action	Replacement in deficiency states and maintenance of homeostasis.	Lowers blood glucose by: stimulating glucose uptake in skeletal muscle and fat, inhibiting	Acts as an alkalinizing agent by releasing bicarbonate ions. Following oral administration, releases bicarbonate, which is capable of neutralizing gastric acid. T

		hepatic glucose production.	
Reason Client Taking	Patient is experiencing dehydration and electrolyte imbalance	Used due to the patient is in a Diabetic Ketoacidosis state	Given to patient to neutralize blood acid levels
Contraindications (2)	Geriatric patients with NG suctioning Severe liver disease	Hypoglycemia; Allergy or hypersensitivity to a particular type of insulin, preservatives	Patients on sodium-restricted diets Concurrent corticosteroid therapy
Side Effects/Adverse Reactions (2)	Extravasation irritation at IV site.	pruritus, erythema, swelling.	hypocalcemia, hypokalemia, sodium and water retention.
Nursing Considerations (2)	Assess for fluid balance (intake and output, daily weight, edema) Assess for symptoms of hyponatremia	Assess patient periodically for symptoms of hypoglycemia (anxiety; restlessness; tingling in hands, feet, lips, or tongue; chills; cold sweats; cool, pale skin; difficulty in concentration; drowsiness; nightmares or trouble sleeping; excessive hunger;	Assess fluid balance levels Assess patient for epigastric or abdominal pain and frank or occult blood in the stool, emesis, or gastric aspirate.
Key Nursing	Potassium,	Monitor blood	Monitor serum sodium, potassium,

Assessment(s)/Lab(s) Prior to Administration	bicarbonate, sodium	glucose every 6 hr during therapy, more frequently in ketoacidosis and times of stress. A1C may be monitered every 3– 6 mo to determine effectiveness.	calcium, bicarbonate concentrations,
Client Teaching needs (2)	Explain to patient the purpose of the infusion. Advise patients at risk for dehydration due to exposure to extreme temperatures when and how to take NaCL tablets. Inform patients that undigested tablets may be passed in the stool; oral electrolyte solutions are preferable.	Instruct patient on proper technique for administration. Include type of insulin, equipment (syringe, cartridge pens, alcohol swabs), storage, and place to discard syringes. Discuss the importance of not changing brands of insulin or syringes, selection and rotation of injection sites, and compliance with therapeutic regimen. Opened, unused insulin vials should be discarded 1 mo after opening. ● Demonstrate technique for	Emphasize the importance of regular follow-up examinations to monitor serum electrolyte levels and acid-base balance and to monitor progress. Advise patient on sodium-restricted diet to avoid use of baking soda as a home remedy for indigestion.

		mixing insulins by drawing up regular insulin first and rolling intermediate-acting insulin vial between palms to mix, rather than shaking (may cause inaccurate dose).	

Medications Reference (APA):

Jones & Bartlett Learning., & Jones & Bartlett Publishers. (2019). *Nurse's drug handbook*.

Sudbury, MA: Jones and Bartlett Publishers

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient exhibits no signs of drowsiness. Patient is not oriented to the time and place. Patient is very lethargic and an altered level of consciousness. Patient is diaphoretic and her skin is clammy and cool to touch.
INTEGUMENTARY (2 points):	Braden Score : 13

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Skin color: **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Patient is Caucasian and has a light skin tone. Skin is clammy and cool to touch, there are no signs of infection or drainage from anywhere on the skin. There are no lesions present and no signs of skin breakdown. Patient's hair is black. There are no rashes or bruises present. Patient's slight tenting of the skin due to dehydration. Patient is given a Braden score of 13 because she is at moderate risk of skin breakdown due to dehydration.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient has black hair and shows no sign or hair loss. Head is midline and no signs of deviation. Patient has a midline trachea, there is no sign of deviation. Turbinates are equal bilaterally. There is no sign of drainage from her ears and tympanic membrane is pearly grey. There are no lesions on the patient's ears. Patient does not wear glasses. Patient's oral mucosa is dry with no lesions and no notable abnormalities. Patient's dentition is good, teeth are white in color.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Clear S1 and S2 heard in patient, and has a normal sinus rhythm. Patient is not monitored by a telemetry. Radial and pedal pulses are assessed. They are strong bilaterally, graded at 2+. Capillary refill is assessed and noted at less than 2 seconds on fingers and toes. Patient does have neck vein distention due to dehydration. Patient does not have a central line put in.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Clear lung sounds heard bilaterally. Both anterior and posterior lungs are auscultated. No crackles or wheezing noted. Patient does use accessory muscles during respirations. Respirations are noted to be deep and rapid like Kussmal respirations. Patients trachea is midline with not deviations. Patient does show signs of shortness of breath. Patient is but on 2L oxygen via nasal

	cannula.
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 ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Pt. does not have tenderness with palpation in any quadrants. Patient has a negative Murphy's sign. Patient does not have rebound tenderness is not present. Normoactive bowel sounds present upon auscultation. Patient last bowel movement was this morning.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Pt. gets up to use the bathroom without the use of assistive devices. Urine is normal in color and frequency Sent to the lab to check for Ketones. Pt. denies the presence of pain during urination.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐**	Fall Risk Score : 30 Pt. does not have full ROM throughout extremities due to altered level of consciousness. Hand grip and strength are not equal and strong throughout. Pt. is not up and does not use assistive devices and does not need support to

Fall Risk: Y ☐ N☐ **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	stand and walk. Pt. is considered a fall risk due to recent episode of dehydration, lethargy, and altered level of consciousness.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. Pt is not oriented to person, place and time. Pt. cannot follow commands and has purposeful and equal strength/motor response throughout all extremities. Speech not clear present. Pupils are not equal, round, and reactive and accommodate to light.
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):**	Pt is 18 year old Caucasian female. She is in high school. Pt. does not identify with a religion. She lives at home with her mother and her father. Pt. has support at home from her father and mother. She is able and willing to care for him. Pt. is not a everyday smoker and does not drink alcohol occasionally.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0900	**100**	**100/70**	**32**	**NA**	**98**
na	**na**	**na**	**na**	**na**	**na**

Vital Sign Trends:

Patient does not have significant vital sign declines or accelerations. Patient has an acceleration respiration rate due to the Kusumal's respirations.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	**numeric scale 0 - 10**	**Abdomen**	**7/10**	**"gnawing pain."**	**Pt. took Tylenol to alleviate abdominal pain**
1200	**numeric scale 0 -10**	**Abdomen**	**2/10**	**Comfortable**	**Pt found relief from the aspirin that was taken**

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IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	IV is placed on right antecubital fossa vein. Site is free of redness and swelling. Appears dry and intact. Pt. has a hep lock and IV flushed successfully with 10 mL of D5W saline solution.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/A	N/A

Nursing Care

Summary of Care (2 points)

Overview of care: Patient demonstrates an altered level of consciousness and extreme lethargy.

Procedures/testing done: Blood test, EKG, ABG

Complaints/Issues: Diabetic ketoacidosis

Vital signs (stable/unstable): High respirations

Tolerating diet, activity, etc.: N/A

Physician notifications: No specific physician notifications

Future plans for patient: Educations on proper insulin administration and diet.

Discharge Planning (2 points)

Discharge location: Patient's home in Champaign, IL

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: N/A

Education needs: Pain management and assistance with ADLs.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

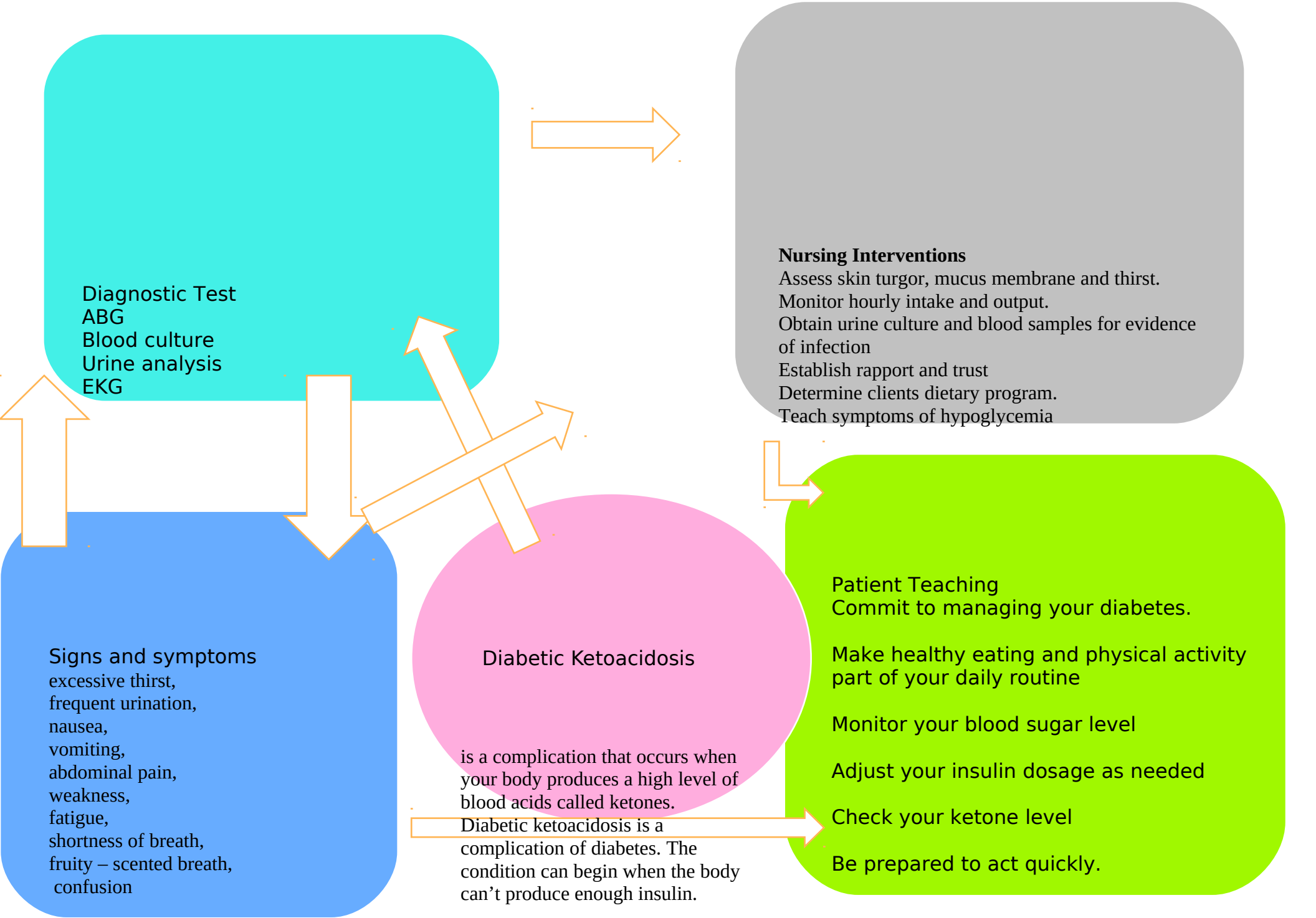
Nursing Diagnosis	**Rational**	**Intervention (2 per dx)**	**Evaluation**
● Include full nursing diagnosis with "related to" and "as evidenced	● Explain why the nursing diagnosis was chosen		● How did the patient/family respond to the nurse's actions? ● Client response, status

by" components			of goals and outcomes, modifications to plan.
1. **Risk for fluid volume deficit as evidence by dehydrations symptoms.**	**When patient is experience DKA, the patient will have polyuria and polydipsia. Therefore, the patient is losing excessive amount of fluid.**	**1. Assess skin turgor, mucus membrane and thirst. 2. Monitor hourly intake and output.**	**Patient's family is cooperative. Both the client and the client's family want to reduce increase fluid levels in the patient.**
2. **Risk for infection as evidence by elevated glucose levels.**	**Increased glucose levels will lead to increased risk for infections**	**1. Administer antibiotics as indicated. 2. Obtain urine culture and blood samples for evidence of infection**	**Patient's family is cooperative. Both the client and the client's family want to prevent infection.**
3. **Deficient knowledge related to unfamiliarity with risk factors, treatment and**	**This nursing diagnosis is important because of the new diagnosis of DKA.**	**1. Establish rapport and trust 2. Teach symptoms of hypoglycemia**	**Patient's family is cooperative. Both the client and the client's family want to understand the complications and learn the mechanisms of DKA.**

prevention of the disease as evidence by uncontrolled glucose levels.			
4. **Imbalanced nutrition related to hypermetabolic state as evidence by increased urinary output.**	**This nursing diagnosis is due to excessive urination.**	**1. Determine clients dietary program. 2. Monitor weight daily.**	**Patient's family is cooperative. Both the client and the client's family wants the patient to better her nutritional status.**

Other References (APA):

Concept Map (20 Points)


Diagnostic Test
ABG
Blood culture
Urine analysis
EKG
Nursing Interventions
Assess skin turgor, mucus membrane and thirst.
Monitor hourly intake and output.
Obtain urine culture and blood samples for evidence of infection
Establish rapport and trust
Determine clients dietary program.
Teach symptoms of hypoglycemia
Signs and symptoms
excessive thirst,
frequent urination,
nausea,
vomiting,
abdominal pain,
weakness,
fatigue,
shortness of breath,
fruity – scented breath,
confusion
Diabetic Ketoacidosis
is a complication that occurs when your body produces a high level of blood acids called ketones. Diabetic ketoacidosis is a complication of diabetes. The condition can begin when the body can't produce enough insulin.
Patient Teaching
Commit to managing your diabetes.
Make healthy eating and physical activity part of your daily routine
Monitor your blood sugar level
Adjust your insulin dosage as needed
Check your ketone level
Be prepared to act quickly.

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