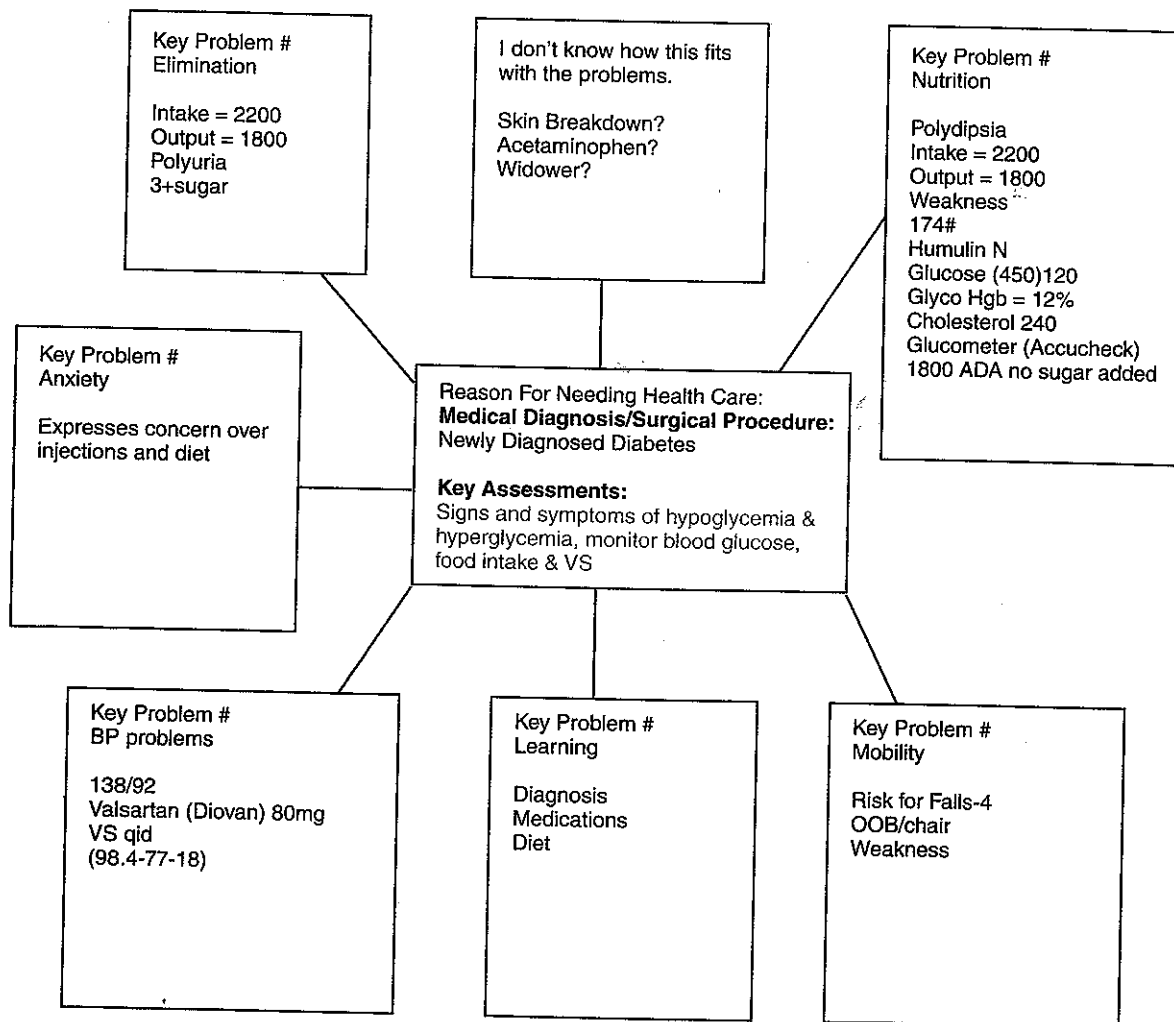


## Adding Assessments for Primary Medical Diagnoses

Now that you have most of your patient data arranged on your concept care map, you should add key assessments to the central box that contains the reason (the medical diagnosis) for admission to the health-care setting. These are important assessments that you will focus on while you are with the patient. The results of these assessments will tell you whether the patient is making progress toward a healthier state in which his diabetes is under control.

In a patient with diabetes, the key assessments consist of watching for hypoglycemia or hyperglycemia and assessing blood glucose levels. Hypoglycemia typically causes weakness, dizziness,

sluggishness, hunger, irritability, sweating, paleness, a rapid heart rate, tremors, headache, and changes in mental functioning, such as confusion. The potential for hypoglycemia in the hospital setting is high until food intake, exercise, and the amount of insulin the patient receives are in careful balance. The classic signs of hyperglycemia and ketosis are polydipsia (excessive thirst), polyuria (excessive urination), and polyphagia (excessive appetite). The most important problem to watch for in this patient is an insulin reaction. When giving the patient his insulin, make sure you know his blood glucose level and that he is going to eat if you are giving a dose before eating a meal. Always monitor vital signs. The center of the care map should look like Figure 3-11.



● Figure 3.11 Sloppy copy with key assessments highlighted.

instruction on slowing down the development of peripheral vascular complications, although these complications are inevitable. Peripheral vascular complications of diabetes will affect circulation and sensation in the extremities, with skin breakdown and ulcerations as common consequences. Also, with diabetes, healing of wounds is much slower than normal. It is clear now that the skin breakdown risk that you put in the box labeled "I don't know how this fits with the problems" at the top of the map fits well with *Ineffective Peripheral Tissue Perfusion*.

### Mobility

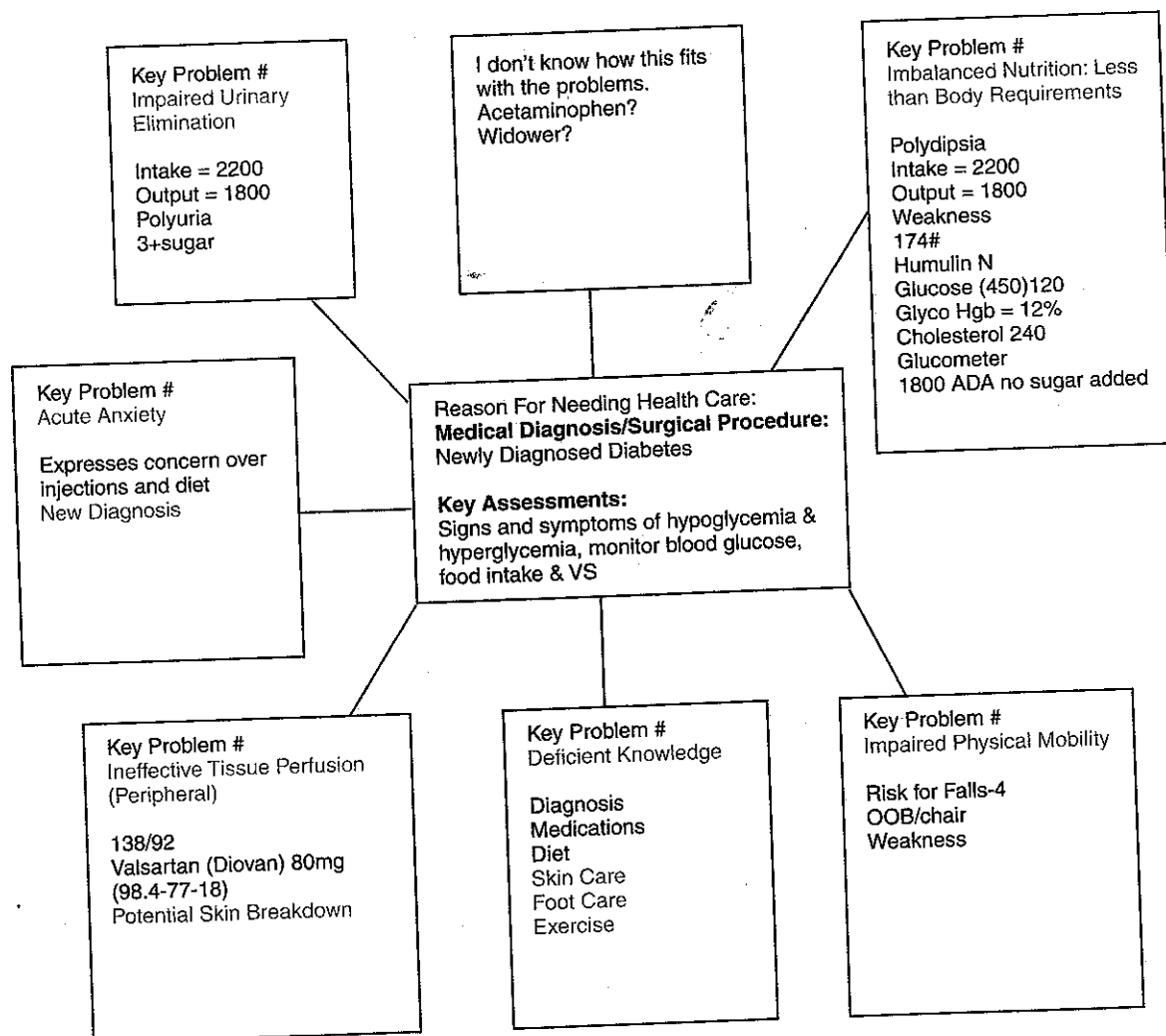
The patient has an increased risk of falling caused by weakness, and he is permitted to be OOB/chair.

He can be diagnosed with *Impaired Physical Mobility*, which is defined as a "limitation in independent, purposeful physical movement of the body or of one or more extremities."<sup>8</sup> Your map should now look like Figure 3-12.

### Step 3: Mapping Cross-Links

Your concept care map is almost complete. Step 3 involves analyzing the relationships between the nursing diagnoses in order to make meaningful associations. The links must be accurate, meaningful, and complete. In concept care maps, the concepts you must link are the nursing diagnoses.

You must be able to state explicitly why you believe the diagnoses are related. Your faculty

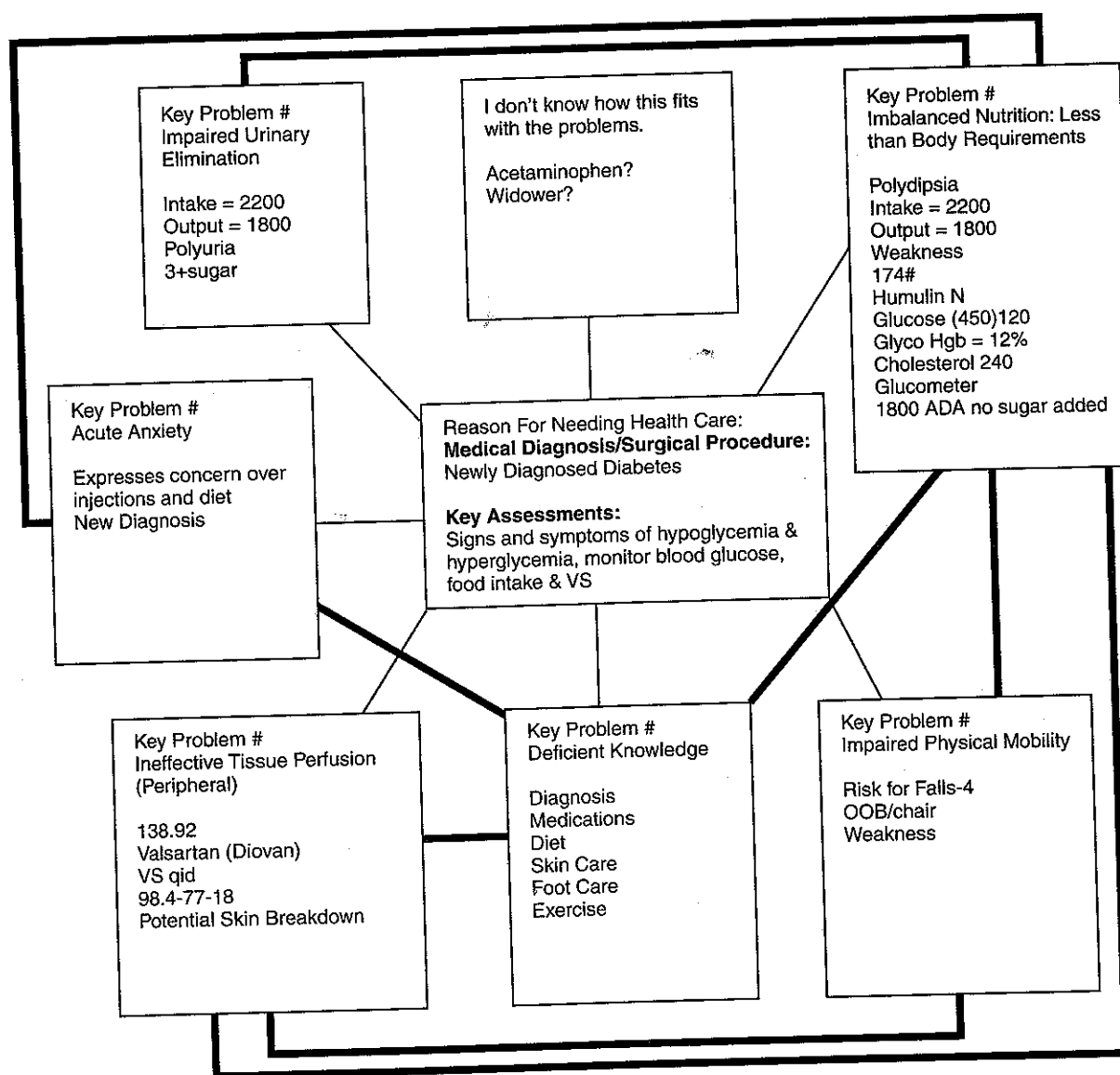


● Figure 3.12 Sloppy copy with NANDA labels highlighted.

will be able to look at your map and see what was (or was not) in your mind and ask you questions about the relationships you indicated—so be prepared with good answers. Some faculty may prefer that you write out why these linkages are important. The sloppy copy should now look like Figure 3.13.

Your explanations of the primary relationships between nursing diagnoses will be based on your knowledge of the disease process, as in the following examples.

**Imbalanced Nutrition and Impaired Urinary Elimination:** These two concepts are always linked in any disease. What goes in and is metabolized must come out in equal amounts or there will be a health problem. Metabolism is altered with diabetes because a lack of insulin causes blood glucose to rise, and excess glucose spills into the urine. As glucose is excreted, water is pulled out of the body by osmosis, creating an osmotic diuresis. Osmosis is the process by which a solution of higher



● Figure 3.13 Sloppy copy with links between nursing diagnoses.

4 Nursing Strategies to Attain Outcomes: So Many Problems, So Little Time 89

Problem # _____: General Goal:	
Predicted Behavioral Outcome Objective (s): The patient will... _____ _____ _____ on the day of care.	
Nursing Strategies	Patient Responses
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____
Evaluation: Summarize patient progress toward outcome objectives: _____ _____	

Problem # _____: General Goal:	
Predicted Behavioral Outcome Objective (s): The patient will... _____ _____ _____ on the day of care.	
Nursing Strategies	Patient Responses
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____
Evaluation: Summarize patient progress toward outcome objectives: _____ _____	

● Figure 4.2 Sample format for writing problems, goals, objectives, strategies, responses, and summary.

Problem # <u>1</u> : Imbalanced Nutrition: Less than body requirements General Goal: To improve the patient's nutritional status	
Predicted Behavioral Outcome Objective (s): The patient will...maintain his blood glucose between 80 and 120 mg/dl by eating his 1800-calorie ADA diet and administering insulin injections as scheduled...on the day of care.	
Nursing Strategies	Patient Responses
1. Assess abdomen: bowel sounds, tenderness, distention, BMs 2. Assess blood glucose with glucometer at 0800 and 1100 3. Assess S/S of hypoglycemia and hyperglycemia 4. Monitor appetite—1800 cal ADA, no sugar added 5. Measure fluid intake and output 6. Administer insulin on time 7. Check for additional blood work 8. Monitor patient for orthostatic hypotension and weakness 9. Ambulate carefully to avoid falls	1. BS all quads, nontender, nondistended, no BM 2. 60 at 7:30, 100 at 11:30 3. 7:45, clammy/sweaty, dizzy, hungry 4. Ate 90% breakfast, 50% lunch 5. I=400, 350, 200 O=250, 225, 300 6. 8:00 insulin held, Dr. notified, continue glucometer measurements and call for further orders after each BS 7. K=3.8 8. Steady while standing and walking BP 124/60 standing 9. Able to walk without assistance to BR
Evaluation: Summarize patient progress toward outcome objectives: Need to continue to carefully monitor for hypoglycemia and hyperglycemia because diet, insulin, and blood sugar still not coordinated, is stronger and is cautious with movement.	
Problem # <u>2</u> : Anxiety General Goal: Decrease anxiety	
Predicted Behavioral Outcome Objective (s): The patient will...verbalize concerns about his disease and the changes that must be made in his lifestyle...on the day of care.	
Nursing Strategies	Patient Responses
1. Assess current level of anxiety 2. Use empathy 3. Use therapeutic touch 4. Use therapeutic humor	1. Appeared anxious during hypoglycemic episode 2. Verbalized concerns about disease 3. Accepted touch, eased anxiety 4. Responded by smiling, eased anxiety
Evaluation: Summarize patient progress toward outcome objectives: Patient stated he was concerned about learning how to give his own injections and how to prepare meals. Communication techniques effective in gaining cooperation and mutual goal setting, and helped to control anxiety by verbalization of concerns.	
Problem # <u>3</u> : Deficient knowledge General Goal: Increase knowledge	
Predicted Behavioral Outcome Objective (s): The patient will...decide in collaboration with the nurse what aspects of diabetic teaching protocol he would like to focus on during... the day of care.	
Nursing Strategies	Patient Responses
1. Assess current level of knowledge and establish what the patient most wants to learn about during the day of care 2. Assess resources available for teaching, such as diabetic educator, dietitian, programs, or movies 3. See teaching plan for: —what diabetes is and how it affects health (signs and symptoms) —Medications —Diet —Skin care —Exercise/activity	1. Wants to know about hypoglycemia, glucometer monitoring, and insulin injections 2. Diabetes educator visited and will start classes at outpatient clinic when discharged 3. Focused on signs and symptoms, use of glucometer, drawing up insulin, see teaching plan for evaluation of teaching
Evaluation: Summarize patient progress toward outcome objectives: Needs continued practice to use glucometer. Did not need insulin this shift so could not practice self-administration. Did correctly draw up the medication. Can state the signs of hypoglycemia and hyperglycemia. Review of menus not done due to lack of time.	

● Figure 5.1 Steps 4 and 5 of the concept care map.