

DIABETES NURSING CARE

ASSESSMENT

SUBJECTIVE DATA

- Past health Hx
- Medications
- Recent surgery
- Thirst
- Hunger
- Poor healing
- frequent urination
- abdominal pain

OBJECTIVE DATA

- Sunken eyeballs
- dry skin
- hypotension
- weak tachy HR
- dry mouth
- fruity breath
- OGTT $> 200 \text{ mg/dL}$
- FBG $> 126 \text{ mg/dL}$

RISK FACTORS

I

- genetics
- autoimmune disease

II

- obesity
- genetics
- $\uparrow$ triglycerides

DIAGNOSIS

- Ineffective health management
- Risk for unstable blood glucose levels
- Risk for injury
- Risk for peripheral vascular dysfunction

PLANNING + GOALS

- Keep patient involved in their care
- have few hyper/hypoglycemic emergencies
- Adjust lifestyle to accommodate their diagnosis + needs

IMPLEMENTATION

- Monitor blood glucose frequently, especially during acute illness
- Assess patient's ability to perform SMBG and insulin injection
- Assess patient's knowledge of proper diet + exercise
- Teach pt. the signs + symptoms of hypo/hyperglycemia + what to do in each case
- Provide frequent oral care
- Inspect feet daily + encourage pt. to wear proper footwear
- Ensure patient is prepared for travel with enough supplies
- Teach importance of wearing a medical ID bracelet

Diabetes Study Guide For Nursing Students

Marilyn J. Hockenberry, Kelley Ward



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Table of Contents Diabetes Study Guide For Nursing Students

1. Understanding the eBook Diabetes Study Guide For Nursing Students
 - The Rise of Digital Reading Diabetes Study Guide For Nursing Students
 - Advantages of eBooks Over Traditional Books
2. Identifying Diabetes Study Guide For Nursing Students
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Diabetes Study Guide For Nursing Students
 - User-Friendly Interface
4. Exploring eBook Recommendations from Diabetes Study Guide For Nursing Students

- Personalized Recommendations
- Diabetes Study Guide For Nursing Students User Reviews and Ratings
- Diabetes Study Guide For Nursing Students and Bestseller Lists
- 5. Accessing Diabetes Study Guide For Nursing Students Free and Paid eBooks
 - Diabetes Study Guide For Nursing Students Public Domain eBooks
 - Diabetes Study Guide For Nursing Students eBook Subscription Services
 - Diabetes Study Guide For Nursing Students Budget-Friendly Options
- 6. Navigating Diabetes Study Guide For Nursing Students eBook Formats
 - ePub, PDF, MOBI, and More
 - Diabetes Study Guide For Nursing Students Compatibility with Devices
 - Diabetes Study Guide For Nursing Students Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Diabetes Study Guide For Nursing Students
 - Highlighting and Note-Taking Diabetes Study Guide For Nursing Students
 - Interactive Elements Diabetes Study Guide For Nursing Students
- 8. Staying Engaged with Diabetes Study Guide For Nursing Students
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Diabetes Study Guide For Nursing Students
- 9. Balancing eBooks and Physical Books Diabetes Study Guide For Nursing Students
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Diabetes Study Guide For Nursing Students
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Diabetes Study Guide For Nursing Students
 - Setting Reading Goals Diabetes Study Guide For Nursing Students
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Diabetes Study Guide For Nursing Students

- Fact-Checking eBook Content of Diabetes Study Guide For Nursing Students
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
- Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
- Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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