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Type 2 diabetes mellitus Initial assessment

Adult Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

48-year-old man with a new diabetes diagnosis. Care stage: At the first supervised assessment.

Medical history: Recent thirst and polyuria led to a new diagnosis of type 2 diabetes. The patient has not previously received structured diabetes education. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Thirst, frequent urination and uncertainty about meals.

Objective findings and required checks: Raised glucose on clinical evaluation; hydration, feet and cardiovascular risk need assessment.

Physical examination and investigations: Review diagnostic glucose testing, HbA1c, renal function, urine albumin and individualized complication screening.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Type 2 diabetes mellitus: Insulin resistance and progressive insulin-secretory impairment cause chronic hyperglycemia.

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Medical / surgical management

Coordinate nutrition, activity, prescribed medicines, glucose monitoring and complication prevention.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Metformin when prescribed	Improve glycemic control	Review renal function, gastrointestinal effects and local sick-day instructions
prescribed insulin	Provide needed insulin replacement	Check glucose, meal coordination and hypoglycemia risk.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Thirst, frequent urination and uncertainty about meals. Raised glucose on clinical evaluation; hydration, feet and cardiovascular risk need assessment. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize blood glucose instability requiring close monitoring; insufficient fluid replacement for current losses; difficulty sustaining the agreed treatment plan; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Coordinate nutrition, activity, prescribed medicines, glucose monitoring and complication prevention. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about intake, usual treatment and symptoms of low or high glucose. Assess: Check glucose using the prescribed schedule and assess consciousness and hydration.	Blood glucose instability requiring close monitoring. Possible factors: altered insulin effect, intake, illness or treatment. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Glucose moves toward the individualized target without treatment-related hypoglycemia. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates monitoring and explains the personalized sick-day and emergency plan.	1. Verify glucose findings and reassess symptoms rather than treating a number alone. Rationale: Symptoms and trends guide safe interpretation. 2. Coordinate prescribed medication with nutrition and monitor the response. Rationale: Mismatch between treatment and intake can cause dangerous glucose changes. 3. Follow the local emergency pathway for severe hypoglycemia or suspected ketoacidosis. Rationale: These conditions can progress rapidly and require urgent team care. 4. Coordinate nutrition, activity, prescribed medicines, glucose monitoring and complication prevention. Rationale: Insulin resistance and progressive insulin-secretory impairment cause chronic hyperglycemia. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about thirst, intake, vomiting, stools and dizziness. Assess: Monitor weight trend, intake/output, mucosa, circulation and relevant electrolytes.	Insufficient fluid replacement for current losses. Possible factors: intake below requirements or increased fluid loss. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Hydration and circulation improve within the agreed reassessment interval. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized fluid plan and warning signs.	1. Measure intake and losses using age-appropriate methods. Rationale: Accurate trends guide replacement and help prevent overcorrection. 2. Offer oral fluids only when swallowing, consciousness and the treatment plan permit; otherwise implement prescribed replacement. Rationale: The safest route depends on aspiration risk and clinical severity. 3. Reassess perfusion, weight and laboratory trends after prescribed replacement. Rationale: Both continued dehydration and fluid overload require prompt recognition.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about missed treatment, side effects, cost and beliefs without blame. Assess: Review the medication list, refill access and ability to follow instructions.	Difficulty sustaining the agreed treatment plan. Possible factors: treatment burden, access barriers or uncertainty. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Identifies one practical barrier and agrees on a feasible solution. Longer-term: Before the clinically approved transition or agreed follow-up: Has an affordable treatment and follow-up plan verified with the team.	1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different responses. 2. Reconcile medicines and involve pharmacy or community services when needed. Rationale: A simpler, accurate plan can reduce avoidable errors. 3. Agree reminders, support and follow-up using shared decision-making. Rationale: Plans are more sustainable when they fit the person's circumstances.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to	Learning needs about the condition and care plan. Possible	Short-term: After the first indicated intervention, at the	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach monitoring, foot care, hypoglycemia recognition and the personalized sick-day plan. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach monitoring, foot care, hypoglycemia recognition and the personalized sick-day plan.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Vomiting, severe dehydration, altered consciousness or suspected severe hypo/hyperglycemia needs urgent assessment.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Insulin resistance and progressive insulin-secretory impairment cause chronic hyperglycemia.

- Priority concerns: Blood glucose instability requiring close monitoring; Insufficient fluid replacement for current losses; Difficulty sustaining the agreed treatment plan; Learning needs about the condition and care plan.

- Vomiting, severe dehydration, altered consciousness or suspected severe hypo/hyperglycemia needs urgent assessment.

- Teach monitoring, foot care, hypoglycemia recognition and the personalized sick-day plan.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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