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Home diabetes foot care Response monitoring

Community Health Nursing | Response monitoring

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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.

Clinical assessment

Subjective: Cannot easily inspect the soles and reports poorly fitting footwear.

Objective findings and required checks: Reduced protective sensation; skin and circulation need structured assessment.

Physical examination and investigations: Review skin, footwear, sensation, pulses, glucose management and referral needs.

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

Clinical focus and pathophysiology

Home diabetes foot care: Neuropathy and impaired circulation can allow unnoticed injury and delayed healing.

Medical / surgical management

Support daily inspection, suitable footwear and timely professional review of any lesion.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed diabetes medicine	Support the individualized glucose plan	Monitor glucose and adverse effects

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Medicine / treatment	Purpose	Nursing checks
no self-treatment of infected ulcers	Foot infection needs clinical assessment	Avoid unapproved caustic products or cutting calluses.

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

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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: Compare the current assessment with the documented baseline and identify benefit, harm or lack of response.

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 discomfort, usual mobility and ability to reposition. Assess: Inspect skin, pressure points, wound characteristics and moisture exposure.	Skin damage or vulnerability to pressure-related injury. Possible factors: pressure, moisture, impaired sensation or tissue injury. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Skin is protected and existing damage shows no avoidable deterioration. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates the individualized skin-protection plan.	1. Assess skin and pressure risk using the local tool and clinical judgment. Rationale: Risk identification guides targeted prevention. 2. Individualize repositioning, heel offloading and pressure redistribution. Rationale: Reducing sustained pressure and shear protects tissue perfusion. 3. Use appropriate wound care and moisture management; refer for nutrition or specialist advice when needed. Rationale: Healing requires local protection and support for underlying contributors. 4. Support daily inspection, suitable footwear and timely professional review of any lesion. Rationale: Neuropathy and impaired circulation can allow unnoticed injury and delayed healing. 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 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: At the next scheduled reassessment, with its interval chosen for acuity: 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.	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 which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	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: At the next scheduled reassessment, with its interval chosen	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.	for acuity: 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 inspection with a mirror or helper, safe washing/drying and immediate reporting of breaks in the skin. 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 inspection with a mirror or helper, safe washing/drying and immediate reporting of breaks in the skin.

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

A red hot swollen foot, new ulcer, spreading infection, black tissue or systemic illness needs prompt 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

- Neuropathy and impaired circulation can allow unnoticed injury and delayed healing.

- Priority concerns: Skin damage or vulnerability to pressure-related injury; Blood glucose instability requiring close monitoring; Daily self-care needs exceed current ability; Learning needs about the condition and care plan.

- A red hot swollen foot, new ulcer, spreading infection, black tissue or systemic illness needs prompt urgent assessment.

- Teach inspection with a mirror or helper, safe washing/drying and immediate reporting of breaks in the skin.

Exam / viva: Which observations demonstrate response, and which findings would require revising or stopping the current intervention?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

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Nursing Mental Health and Community Concepts, 2e - Open RN / WisTech Open, 2025
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https://wtcs.pressbooks.pub/pharmacology2e/

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