#1 GLYCEMIC CONTROL

**Related to:** Alteration in disease process, meal plan, medications.

**Expected Outcomes/Goals:** Maintain glycemic control and avoidance of hypo- and hyperglycemia and DKA.

**Nursing Interventions/Plan of Care (Circle all that apply):**

1. Monitor blood glucose levels with glucose meter. When eating: before meals, bedtime and 2 am; when NPO: every 4 hours.
2. For hypoglycemia, follow hypoglycemia protocol:
   a. For patient who can take PO, administer 20 grams of carbohydrates (i.e., 6 oz juice, or 4 glucose tablets.)
   b. For patient who can not take PO, administer 25mL D50 IV push.
   c. Check fingerstick glucose meter every 15 minutes and repeat above treatment until blood glucose level is ≥100 mg/dl.
3. Follow-up, set up appointment with private physician or UCSF Diabetes Clinic at (415) 353-2605.

#2 KNOWLEDGE DEFICIT

**Related to:** New diagnosis, alteration in medications, disease process.

**Expected Outcomes/Goals:** Ability to do self-management of diabetes.

**Nursing Interventions/Plan of Care (Circle all that apply):**

1. Patient/family education per Diabetes Teaching Record and or AICP.
2. Recommend UCSF Diabetes Teaching Center. Call (415) 353-2266 for class schedule.

#3 DISCHARGE PLANNING

**Related to:** Management after discharge.

**Expected Outcomes/Goals:** Outcomes/Goals: Patient and/or care giver demonstrates knowledge and ability to care for the patient at home.

**Nursing Interventions/Plan of Care (Circle all that apply):**

1. Refer to admission assessment for anticipated discharge needs.
2. Initiate discharge instructions and record on Discharge Follow-up summary
3. Initiate/participate in patient care conferences of family conferences
Evaluation of the patient is based on the patient care goals and the patient's plan for care, treatment, and services.

Evaluation/Progress towards goals:

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For additional problems, use the Blank Additional Problems Template
For additional progress notes, use the Blank Progress-Towards-Goals Template