Type 2 Diabetes Nursing Care Plan Template

Patient Information

- Full Name: ___________________________________
- Date of Birth: ____ / ____ / ________
- Gender: _____________________________________
- Ethnicity: ___________________________________
- Language Preference: _________________________
- Patient ID: ___________________________________
- Contact Number: ______________________________
- Email Address: ________________________________

ASSESSMENT

Medical History:

Diabetes History:

Date of Diagnosis: ___________

Duration of Diabetes: _______ year(s) _______ month(s)

Previous Blood Glucose Control:

- HbA1c History: ___________ Date: ___________
- History of Hypoglycemic Episodes: ______ [Yes/No]
  - Details: ____
- History of Diabetic Ketoacidosis/Hyperglycemic Hyperosmolar State: ______ [Yes/No]
  - Details: ____

Comorbid Conditions:

Hypertension: ______ [Yes/No]

- Control: _____________________________________
- Medication: __________________________________

Hyperlipidemia: ______ [Yes/No]

- Latest Cholesterol Levels: _______________________
- Medication: __________________________________

Heart Disease: Yes / No

- Details: ____

Other Relevant Conditions: ____

Notes:

Current Medications:

Diabetes Medications:

Non-Diabetes Medications:

Potential Drug Interactions:

Family History:

- [ ] Family History of Type 1 Diabetes [Relationship: ________________________]
- [ ] Family History of Type 2 Diabetes [Relationship: ________________________]

Other Chronic Illnesses:

Notes:

Diabetes Assessment:

Lifestyle Evaluation:

Diet:

Physical Activity:

Smoking Status: _______________________

Alcohol Use: _______________________ [Frequency: ___________]

Notes:

Anthropometric Measurements:

Weight: ____________ kg/lbs

BMI: ____________

Blood Pressure: ____________ mmHg

Waist Circumference: ____________ cm/in

Notes:

Foot Examination:

Findings (e.g., ulcers, calluses, neuropathy):

Vascular Assessment:

Notes:

Mental Health Assessment:

Mood and Affect:

Signs of Depression/Anxiety: _______ [Yes/No]

- Details: ____

Cognitive Function:

Notes:

Self-Management Skills and Practices:

Diet Adherence:

Medication Adherence:

Blood Glucose Monitoring: Frequency: ____________ [Results: ____________]

Notes:

DIAGNOSIS

Primary Diagnosis: Type 2 Diabetes Mellitus

Criteria for Diagnosis:

- ☐ Fasting Plasma Glucose ≥126 mg/dL
- ☐ 2-hour Plasma Glucose ≥200 mg/dL during an Oral Glucose Tolerance Test
- ☐ HbA1c ≥ 6.5%
- ☐ Random Plasma Glucose ≥200 mg/dL with symptoms of hyperglycemia

Notes:

Secondary Diagnoses:

☐ **Risk for Infection:**

Criteria:

- ☐ Chronic hyperglycemia
- ☐ History of frequent infections or delayed wound healing
- ☐ Peripheral neuropathy or vascular insufficiency
- ☐ Immune function alterations due to elevated blood glucose levels

Notes:

☐ **Risk for Altered Skin Integrity:**

Criteria:

- ☐ Peripheral neuropathy
- ☐ Signs of peripheral vascular disease
- ☐ Reduced mobility or obesity increasing pressure on skin areas
- ☐ History of skin complications or ulcers

Notes:

- [ ] **Impaired Coping:**

Criteria:

- [ ] Stress related to diabetes management
- [ ] Signs of depression, anxiety, or emotional distress
- [ ] Difficulty adhering to diabetes management regimen
- [ ] Lack of social support or resources for diabetes care

Notes:

Other Potential Secondary Diagnoses:

- [ ] **Chronic Pain:**

Criteria: Chronic discomfort, particularly in extremities, possibly due to neuropathy or vascular insufficiency.

- [ ] **Disturbed Sleep Pattern:**

Criteria: Difficulty maintaining sleep, frequent awakenings, or non-restorative sleep, possibly linked to nocturnal hypoglycemia or neuropathy pain.

- [ ] **Knowledge Deficit:**

Criteria: Limited understanding or misinformation regarding diabetes management, diet, exercise, and self-care practices.

- [ ] **Nutritional Imbalance: Over/Under:**

Criteria: Inadequate or excessive nutritional intake compared to diabetes dietary guidelines.

Goals of Care

Glycemic Control:

- [ ] Aim to manage and maintain blood glucose levels within individualized target ranges.
- [ ] **Specific Targets:** Set achievable goals (e.g., “Reduce HbA1c to less than 7% within 3 months”).
- [ ] **Continuous Monitoring:** Encourage regular self-monitoring of blood glucose.

Notes:

Education and Self-Management:

- [ ] Offer comprehensive education on diabetes management, covering medication, diet, and lifestyle changes.
- [ ] Implement self-management training including glucose monitoring, insulin administration, and recognizing signs of complications.

Notes:

Preventing Potential Complications:

- [ ] **Cardiovascular Health:** Address risk factors like hypertension, hyperlipidemia, and smoking.
- [ ] **Nephropathy:** Monitor kidney function regularly and manage blood pressure.
- [ ] **Retinopathy:** Advise annual eye exams to detect changes early.
- [ ] **Neuropathy:** Perform regular nerve function tests and promote foot care.

Notes:

Weight Management and Lifestyle Improvement:

- [ ] Encourage healthy weight through a balanced diet and physical activity.
- [ ] Provide tailored dietary recommendations considering cultural preferences and socioeconomic factors.
- [ ] Promote physical activity aligned with the patient’s abilities and interests.

Notes:

Mental Health:

- [ ] Manage stress through counseling, support groups, and stress-reduction techniques like mindfulness or yoga.
- [ ] Screen for and address symptoms of depression or anxiety.
- [ ] Enhance coping strategies and resilience.

Notes:

Foot Care:

- [ ] Educate on regular foot inspection and care.
- [ ] Advise on the selection of appropriate footwear.
- [ ] Emphasize the importance of professional care for any foot problems.

Notes:

Nursing Interventions

Intervention Category	Description	Specific Actions	Notes
Medication Management	Educate on oral medications and insulin therapy, emphasizing adherence.	• Discuss the purpose and effects of each medication. • Review proper administration techniques. • Address concerns about side effects.	
Nutritional Counseling	Provide individualized dietary guidelines.	• Assess current dietary habits. • Offer guidance on balanced meals and carbohydrate counting. • Discuss how to read nutrition labels.	
Exercise Recommendations	Suggest specific exercises and durations.	• Tailor exercise plans to the patient's physical ability and interests. • Include aerobic, strength, and flexibility exercises. • Advise on gradual progression and safe practices.	

Blood Glucose Monitoring	Instruct on regular self-monitoring.	• Demonstrate how to use a glucometer. • Discuss the optimal times for testing. • Explain how to interpret and record results.	
Education on Diabetes Management	Provide resources for patient education.	• Offer written materials, websites, and support groups. • Teach about recognizing and managing hypo- and hyperglycemia. • Review the importance of regular check-ups.	
Foot Care Education	Educate on appropriate footwear and signs needing professional care.	• Instruct on daily foot inspection. • Discuss the selection of proper footwear. • Emphasize the importance of prompt attention to foot injuries or changes.	
Stress Management Techniques	Offer stress management techniques and mental health support resources.	• Teach relaxation techniques like deep breathing or meditation. • Encourage participation in stress reduction activities. • Provide information on mental health services.	

Referral to Specialists	Consider referrals to endocrinologists, dietitians, podiatrists, ophthalmologists, cardiologists, and diabetes educators.	- Assess the need for specialist consultation. - Facilitate referrals and coordinate care. - Ensure continuity of care with all healthcare providers.	

EVALUATION

- **Regular Wound Assessment:**
  - Reassess the wound at each visit for signs of healing or infection.
  - Document size, depth, color, odor, and any discharge.
  - Evaluate the effectiveness of wound dressings and treatment.
- **Medication Response Monitoring:**
  - Evaluate the patient's response to antibiotics and other medications.
  - Monitor for side effects and signs of allergic reactions.
  - Assess adherence to medication regimen.
- **Recovery Progress Tracking:**
  - Monitor overall recovery progress, noting improvements or any complications.
  - Document changes in wound appearance and patient’s pain levels.
  - Assess mobility and functionality affected by the wound.
- **Vital Signs Monitoring:**
  - Regularly check vital signs including temperature, heart rate, blood pressure, and respiratory rate.
  - Look for signs of systemic infection or sepsis.
- **Symptom Monitoring:**
  - Continuously observe for new or worsening symptoms of infection such as increased pain, redness, swelling, or fever.
  - Monitor for systemic symptoms like fatigue, dizziness, or confusion.
- **Laboratory Test Review:**
  - Review results of blood tests, including infection markers such as white blood cell count.
  - Evaluate any relevant imaging or diagnostic test results.

- **Wound Culture Follow-up:**
  - If applicable, schedule and review follow-up wound cultures to identify specific pathogens.
  - Adjust antibiotic therapy based on culture results.
- **Patient Feedback:**
  - Gather feedback from the patient regarding symptoms, pain levels, side effects, and general well-being.
  - Assess patient’s understanding of the care plan and any concerns.

Additional Notes:

Follow-up:

- **Follow-up Date:** ____ / ____ / ________

Nurse's Signature: ____________________________ Date: ____ / ____ / ________

Physician's Notes and Recommendations

Physician's Signature: ____________________________ Date: ____ / ____ / ________

Patient Acknowledgment I have reviewed the Type 2 Diabetes Nursing care plan and understand the information provided.

Patient's Signature: ____________________________ Date: ____ / ____ / ________