**Support for Patient Centered Concept Map**

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NURS-FPX6011 Evidence-Based Practice for Patient-Centered Care and Population Health

Instructor Name

Date

Concept maps are a tool that can be used to develop an individualized plan of care. Evidence-based practice should support the planned interventions to meet the patient’s needs. The attached concept map was developed to plan care for a diabetic patient who has been non-compliant with her self-care regimen.

**Patient Needs Analysis**

The most important nursing diagnosis for this patient is Risk for unstable blood glucose level(Ladwig et al., 2019). The patient has reported several factors that put her at risk for this diagnosis. She has had episodes of hypoglycemia where her family has called 911 and has continued to have difficulty with blood glucose monitoring and reports not eating well. She is reporting declining interest in overall diabetes management over the past few years. The second most important nursing diagnosis is Ineffective health management(Ladwig et al., 2019). The patient has reported feeling an overall loss of interest and hopelessness in meeting glycemic goals over the past few years. Additionally, she has reported feeling overwhelmed with taking care of her grandchildren which has been intermittent and unexpected due to school closures related to COVID 19. The third diagnosis that is appropriate for Ana is Readiness for enhanced health management(Ladwig et al., 2019). Ana is seeking care and help now because she recognized her choices are not healthy for her and she is concerned as well as her family.

According to the American Diabetes Association Professional Practice Committee (ADAPPC) standards of care “Significant changes in life circumstances, often called social determinants of health, are known to considerably affect a person’s ability to self-manage their condition” (ADAPPC, 2022b). COVID has had a significant impact on individuals, families, and communities. This patient and her family have been impacted and it is contributing to the patient’s ability to effectively manage her diabetic diagnosis. According to the ADAPPC, “There are four critical times to evaluate the need for diabetes self-management education to promote skills acquisition in support of regimen implementation, medical nutrition therapy, and well-being: at diagnosis, annually and/or when not meeting treatment targets, when complicating factors develop (medical, physical, psychosocial), and when transitions in life and care occur” (2022b). This patient and family are experiencing at least two out of four of these critical times. The intervention to refer for Depression screening and Diabetes Self-Management Education and Support (DSMES) will begin to address some of these barriers.

**Communication Strategies**

The patient has expressed the desire to implement changes to improve diabetic goals. What providers and healthcare staff feels the patient can and should do may not be in line with what is realistic and desired for the patient. It is critical that encounters with this patient promote empowerment and reduce unintentional discouragement. According to the ADAPPC standards of care “A patient-centered communication style that uses person-centered and strength-based language and active listening; elicits patient preferences and beliefs; and assesses literacy, numeracy, and potential barriers to care should be used to optimize patient health outcomes and health-related quality of life” (2022a). Furthermore, the actual language used during encounters is also important. A task force made up of the American Association of Diabetes Educators and the American Diabetes Association representatives submitted a consensus report outlining recommendations in the use of language in diabetic care and education (Dickinson et al., 2017). The outcome from this consensus report includes five main recommendations. Language used by health care team should be 1) neutral, nonjudgmental, based on facts, 2) free from stigma, 3) strength based, respectful, inclusive and imparts hope, 4) fosters collaboration and 5) is person centered (Dickinson et al., 2017). Some specific examples include replacing terms such as “non-compliant” with fact-based language such as, “she has not taken her medication because…”, replacing “diabetic person” with Person with diabetes and “Are you diabetic?” with, “Do you have diabetes” (Dickinson et al., 2017).

The patient is the matriarch of her family. The family has a close relationship with her three children, visiting multiple times per week and sharing meals at least once every weekend. The patient reports caring for her grandchildren is a stressor, however she does not want them to be cared for by someone outside the family. Generally speaking, close familial ties are common in Hispanic culture; therefore it is important to address this barrier while honoring the cultural responsibilities the patient is feeling.

Areas of uncertainty include whether individualized glycemic goals are medically feasible. According to the ADAPPC standards for older adults, “Glycemic goals for some older adults might be reasonably relaxed as part of individualized care, but hyperglycemia leading to symptoms or risk of acute hyperglycemia complications should be avoided in all patients” (ADAPPC, 2022d). The patient has commented she did not want to start insulin, so an open discussion about this with the Primary Care physician could be helpful. Another area of uncertainty is the extent of how much other family members can help with the burden of childcare. The effect of COVID-19 on school systems is an ever-changing factor and the likelihood of school closures and student quarantines remains ever present. It is also uncertain how this will affect the patient’s ability to make routine appointments and diabetic education classes. There are telemedicine options available which could help overcome some barriers, but the patient’s comfort with video visits and video classes is yet to be assessed.

**Value and Relevance of Evidence**

Many resources used as the basis for the patient centered concept map are standards of care developed by the American Diabetic Association. These standards are not meant to “preclude clinical judgment and must be applied in the context of excellent clinical care, with adjustments for individual preferences, comorbidities, and other patient factors” (ADAPPC, 2022c). The American Diabetic Association uses an evidence based grading system to categorize these practice standards with “A” being the highest level of evidence and “ E” being the lowest level of evidence ” (ADAPPC, 2022c). “Recommendations with “A” level evidence are based on large well-designed clinical trials or well-done meta-analyses. Generally, these recommendations have the best chance of improving outcomes when applied to the population for which they are appropriate. Recommendations with lower levels of evidence may be equally important but are not as well supported” (ADAPPC, 2022c). Diabetes can be difficult to manage for patient and their families, the ADA Standards for Medical Care in Diabetes have been continually improved for over 30 years and are a go to resource for health care professionals (ADAPPC, 2022c).

**Conclusion**

The patient’s individual values, beliefs, and lifestyle must be considered in order to provide individualized care. Using evidence-based practices ensures we are using the most up to date and reliable resources to guide our care. Finally, we must utilize effective communication strategies to support patient understanding and their compliance with the recommended interventions.

References

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