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# NURSING CARE FOR POSTPARTUM WOMEN WITH TYPE 2 DIABETES MELLITUS: CASE REPORT

# CUIDADOS DE ENFERMAGEM A PUÉRPERA COM DIABETES MELLITUS TIPO 2: RELATO DE CASO

# ATENCIÓN DE ENFERMERÍA A MUJERES POSPARTO CON DIABETES MELLITUS TIPO 2: INFORME DE CASO

Joana Liu[1], Susana do Vale[2].

[1]Universidade de Évora, Escola Superior de Enfermagem São João de Deus, Évora, Portugal.
[2]Unidade Local de Saúde do Norte Alentejano EPE: Portalegre, Portalegre, Portugal.

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# Abstract

**Introduction:** According to the World Health Organization, Type 2 Diabetes *Mellitus* represents a public health challenge on a global scale, significantly affecting women's health at all stages of life, including the puerperium. **Objective:** To develop a nursing care plan aimed at postpartum women with type 2 Diabetes *Mellitus*, valuing the importance of nursing team intervention in promoting self-care, monitoring possible complications and maintaining glycemic control, ensuring a holistic, humanized approach based on scientific evidence. **Method:** Case report of a 35-year-old postpartum woman, previously diagnosed with type 2 Diabetes *Mellitus*, who underwent vaginal delivery. For the initial evaluation, Nancy Roper's Theoretical Model was used. When preparing the nursing care plan, the taxonomy of the International Classification for Nursing Practice and Nursing Interventions Classification was used. **Results:** Based on the data collected, 5 Nursing Diagnoses were identified: Risk for hypoglycemia, Risk for skin integrity, Current peripheral edema, Risk for infection and Risk for falls. **Conclusion:** The role of the nurse in monitoring and monitoring puerperal women with type 2 Diabetes *Mellitus* is essential to ensure a safe and healthy transition in the postpartum period. Continuous monitoring, prevention of complications and reinforcement of self-care contribute to metabolic stabilization and the woman's physical and emotional well-being.



**Keywords:** Energy Metabolism; Eutocic Delivery; Type 2 Diabetes *Mellitus*.



# Resumo

**Introdução:** De acordo com a Organização Mundial da Saúde, a Diabetes *Mellitus* tipo 2 representa um desafio de saúde pública à escala global, afetando de forma significativa a saúde da mulher em todas as etapas da vida, incluindo o puerpério. **Objetivo:** Desenvolver um plano de cuidados de enfermagem direcionado à puérpera com Diabetes *Mellitus* tipo 2, valorizando a importância da intervenção da equipa de enfermagem na promoção do autocuidado, na vigilância de possíveis complicações e na manutenção do controlo glicémico, assegurando uma abordagem holística, humanizada e baseada em evidência científica. **Método:** Relato de caso referente a uma puérpera de 35 anos, com diagnóstico prévio de Diabetes *Mellitus* tipo 2, submetida a parto eutócico. Para a avaliação inicial, recorreu-se ao Modelo Teórico de Nancy Roper. Já na elaboração do plano de cuidados de enfermagem, utilizou-se a taxonomia da Classificação Internacional para a Prática de Enfermagem e a *Nursing Interventions Classification*. **Resultados:** Com base nos dados colhidos, foram identificados cinco Diagnósticos de Enfermagem, Risco de hipoglicémia, Risco de integridade da pele, Edema periférico atual, Risco de Infeção e Risco de Queda. **Conclusão:** O papel do enfermeiro na vigilância e acompanhamento da puérpera com Diabetes *Mellitus* tipo 2 é fundamental para garantir uma transição segura e saudável no período pós-parto. A monitorização contínua, a prevenção de complicações e o reforço ao autocuidado contribuem para a estabilização metabólica e para o bem-estar físico e emocional da mulher.



**Palavras-chave:** Diabetes *Mellitus* Tipo 2; Metabolismo Energético; Parto Eutócico.



# Resumen

**Introducción:** Según la Organización Mundial de la Salud, la Diabetes *Mellitus* tipo 2 representa un desafío para la salud pública a nivel mundial, afectando significativamente la salud de las mujeres en todas las etapas de la vida, incluido el puerperio. **Objetivo:** Desarrollar un plan de cuidados de enfermería dirigido a mujeres con Diabetes *Mellitus* tipo 2 en posparto, valorando la importancia de la intervención del equipo de enfermería para promover el autocuidado, monitorear posibles complicaciones y mantener el control glucémico, garantizando un enfoque holístico y humanizado basado en evidencia científica. **Método:** Reporte de caso de una mujer de 35 años en posparto, previamente diagnosticada con Diabetes *Mellitus* tipo 2, que tuvo un parto vaginal. Para la evaluación inicial, se utilizó el Modelo Teórico de Nancy Roper. Para la elaboración del plan de cuidados de enfermería, se empleó la taxonomía de la Clasificación Internacional para la Práctica de Enfermería y la Clasificación de Intervenciones de Enfermería. **Resultados:** Con base en los datos recopilados, se identificaron 5 Diagnósticos de Enfermería (DE): Riesgo de hipoglucemia, Riesgo de integridad cutánea, Edema periférico actual, Riesgo de infección y Riesgo de caídas. **Conclusión:** El rol de la enfermera en el seguimiento y control de las puérperas con Diabetes *Mellitus* tipo 2 es esencial para garantizar una transición segura y saludable en el posparto. El seguimiento continuo, la prevención de complicaciones y el refuerzo del autocuidado contribuyen a la estabilización metabólica y al bienestar físico y emocional de la mujer.



**Descriptores:** Diabetes *Mellitus* Tipo 2; Metabolismo Energético; Parto Eutócico.

# Introduction

According to the World Health Organization[1], the number of individuals diagnosed with diabetes worldwide increased from 108 million in 1980 to 422 million in 2014. It is estimated that approximately 1.5 million deaths are directly caused by this disease each year. Between 2000 and 2019, there was also a 3% increase in age-adjusted mortality rates from diabetes.

In Portugal, 79,241 new cases of diabetes were diagnosed in 2022, with 879,853 people currently registered with the condition in health centers. It is estimated that by 2030, the number of people with diabetes could reach 643 million, rising to 783 million by 2045[2].

In the 20-79 age group (corresponding to 7.8 million people), the prevalence was 14.1% in 2021, representing approximately 1.1 million Portuguese people with diabetes. It is also noteworthy that more than a quarter of people aged 60-79 live with this disease, the majority of them are male. Type 2 diabetes accounts for approximately 90% of diagnosed cases[3].

According to IDF (International Diabetes Federation), the Diabetes *Mellitus* is characterized by altered insulin secretion and varying degrees of peripheral insulin resistance that can cause hyperglycemia.

Diabetes *Mellitus* type 2 (DM 2), also known as non-insulin-dependent diabetes, it is defined by insufficient production of insulin due to the body's resistance to its action[4]. Hepatic insulin resistance compromises the liver's ability to suppress glucose production, while peripheral resistance hinders glucose uptake by tissues[5]. This combination contributes to the appearance of hyperglycemia, both when fasting and after meals[6]. This form of diabetes develops predominantly in adults and its prevalence tends to increase with advancing age.

According to data from CUF hospitals, in poorly controlled diabetic patients, hyperglycemia can manifest through symptoms such as polydipsia, polyuria, polyphagia and blurred vision. Hypoglycemia, which occurs more frequently in diabetics taking oral antidiabetics, can result from incorrect medication administration or excessive intake. Associated symptoms include unexplained fatigue, dizziness, difficulty thinking, and blurred vision.

Among the main risk factors associated with the development of type 2 DM are obesity, increasing age, inadequate eating habits, high blood pressure, a sedentary lifestyle, dyslipidemia, a family history of diabetes, having had gestational diabetes, among others[7].

Maintaining high blood glucose levels, even in the absence of obvious symptoms that alert the individual to the presence or progression of diabetes, can lead to tissue damage. The main chronic complications of diabetes are cardiovascular disease, neuropathy and amputation, nephropathy, retinopathy, and a predisposition to infections[8].

The diagnosis of diabetes is made by measuring fasting blood glucose, assessing glicated hemoglobin and, in some cases, the oral glucose tolerance test.

According to Standard No. 002/2011 of the Directorate-General for Health, the diagnostic criteria for Diabetes *Mellitus* include one or more of the following parameters:

a) Fasting blood glucose ≥ 126 mg/dl (or ≥ 7.0 mmol/l); or

b) Presence of typical symptoms of decompensation associated with occasional blood glucose ≥ 200 mg/dl (or ≥ 11.1 mmol/l); or

c) Blood glucose ≥ 200 mg/dl (or ≥ 11.1 mmol/l) two hours after administration of 75 g of glucose during the oral glucose tolerance test (OGTT).

d) Glycated hemoglobin (HbA1c) ≥ 6.5%.

The control of DM type 2 consists of maintaining blood glucose levels as close to normal as possible, taking into account factors such as age, lifestyle, comorbidities, and activity level. Regular monitoring of capillary blood glucose levels, before and after meals, allows for daily assessment of disease control. Glycated hemoglobin is the main laboratory indicator used to assess glycemic control over the last three months.

This value should be adjusted individually, according to the individual's clinical profile. Furthermore, controlling blood pressure and cholesterol levels is essential, given their association with worsening diabetes complications[8].

Treatment for DM type 2 begins primarily with lifestyle changes, particularly in diet and regular physical activity. Weight loss, when necessary, can significantly contribute to disease control and, in some cases, is sufficient to maintain stable blood glucose levels for long periods.

When these measures are ineffective, pharmacological therapy with oral antidiabetics (metformin) and, in certain situations, insulin is necessary. Medications to control blood pressure and cholesterol levels are also common[8].

# Method

This case report aims to describe and analyze a specific clinical situation related to the monitoring of a postpartum woman with type 2 DM, contributing to knowledge sharing and improving professional practice. Through this work, I aim to highlight the importance of continuous observation, informed decision-making, and the provision of individualized, evidence-based care. Furthermore, this report allows us to reflect on the challenges associated with managing a chronic condition in the postpartum period, as well as identify opportunities for improvement in the therapeutic, educational, and emotional approach, enriching the experience of healthcare professionals and contributing to future research in the field of maternal health.

The report was prepared through data collection, information provided by the patient herself (in the interview), and information taken from the clinical record through the Glintt and Cárdex systems for accessing her pharmacological therapy. To this end, it was essential to inform and clarify the patient is informed about the case report, its objectives, and purpose, guaranteeing their right to privacy, anonymity, and confidentiality of all collected data. This ensures compliance with the six ethical principles of nursing research, including beneficence, nonmaleficence, fidelity, justice, truthfulness, and confidentiality[9]. Informed consent was obtained from the user, either verbally or in the form of a written document for publication purposes, ensuring the use of their information in the case report, always in accordance with the principle of anonymity and confidentiality. To assess the patient's instrumental functioning, Nancy Roper's Life Activities Model was used. In addition, a flowchart was also used to present the case, following the model CARE Statement & Checklist (CAse REport) from Equator Network[10].

The report is written in Portuguese,under the current Portuguese language spelling agreement. Nancy Roper's Activities of Living Model "is based on the model of life that has the person as its core, defined as an open system in permanent interaction with the environment, comprising twelve activities of daily living (ADLs)"[11].

> "According to the aforementioned model, a nurse must be aware of the vital individuality of each individual and that there are factors that influence their knowledge, attitudes and conduct, such as: biological, psychological, sociocultural, environmental and socioeconomic, since these are closely related to the duration of life in the various stages of development, resulting in a continuum of dependence/independence"[11].

Next, the evaluation of the puerperal woman is presented according to the selected theoretical model (Table 1).

**Table 1: Assessment of Activities of Daily Living.**

| Life Activity | Observation/Evaluation of the patient |
|---|---|
| Maintaining a safe environment | Upon admission, the patient was admitted to a single room, in which ventilation, cleanliness and hygiene conditions were maintained, and safety conditions were also ensured, such as a locked bed, raised rails, maintenance of a low level of the bed plane and a doorbell within reach. During hospitalization, AD had an 18G peripheral venous catheter in her left upper limb. The insertion site was monitored for obvious signs of inflammation, and the catheter dressing remained dry, clean externally, and adherent. The patient's perineum had a grade I laceration, mild edema, and no signs of inflammation. She applied ice and performed perineal hygiene routines. |
| Communication | During his hospitalization, no memory changes were observed. AD maintained a coherent and calm speech throughout, and showed no personality changes. |
| Breathing | She breathes ambient air and does not smoke or drink alcohol. During his hospitalization, she did not require any type of invasive or non-invasive ventilation. Her breathing is regular, mixed, and symmetrical, without the use of accessory muscles. |
| Food: eating and drinking | After the delivery, the postpartum woman is self-sufficient, eating five meals a day and following a diabetic diet, which she tolerates well. Her capillary blood glucose levels are measured before breakfast, lunch, and dinner, and the values are within normal limits. She takes an oral antidiabetic medication (metformin 500 mg) at breakfast and dinner. She maintains her fluid intake, averaging approximately 1 liter of water per day. |
| Elimination | AD maintains sphincter control. There are no changes in bowel or bladder pattern. Regarding the uterus, the patient presented with a well-contracted uterus below the umbilical cord, with sparse blood lochia, odorless, and without clots. |
| Personal hygiene and clothing | Personal hygiene and comfort care are carried out independently in the bathroom by the person themselves. |
| Body temperature control | During hospitalization, the patient was afebrile and maintained a temperature within normal ranges. |
| Mobility | Independent in carrying out this activity, has the ability to sit and move autonomously, move efficiently and walk downhill effectively. According to the Braden scale, the user obtained a score of 21, which indicates no risk of developing pressure ulcers. |
| Work and leisure | During her hospitalization, AD remains, most of the time, resting in bed, accompanied by her husband and daughters during visiting hours. |
| Expression of sexuality | The user is heterosexual and has a partner, who is the father of her daughters. There is no registration of sexually transmitted diseases in your medical history. The resumption of sexual activity is something that, for now, does not raise concerns, as previous pregnancies have been experiences without complications or adversities. |
| Sleep | The AD reports that during hospitalization, she wakes up several times to offer breast milk to the newborn. This practice has somewhat impacted sleep quality, resulting in less restful and significantly reduced rest periods. |
| Death | The patient demonstrates acceptance of death as an integral part of the life cycle, stating that thinking about it does not cause fear or distress. |

After the initial assessment and considering the identified care needs, a nursing care plan was developed. The main health issues were highlighted, based on the International Classification for Nursing Practice[12] Taxonomy. Nursing interventions were guided by the Nursing Interventions Classification (NIC, 5th Edition translation), and the results were monitored according to the settings established by CIPE. To facilitate visualization, the information was organized schematically in a flow diagram, as illustrated in Figure 1.

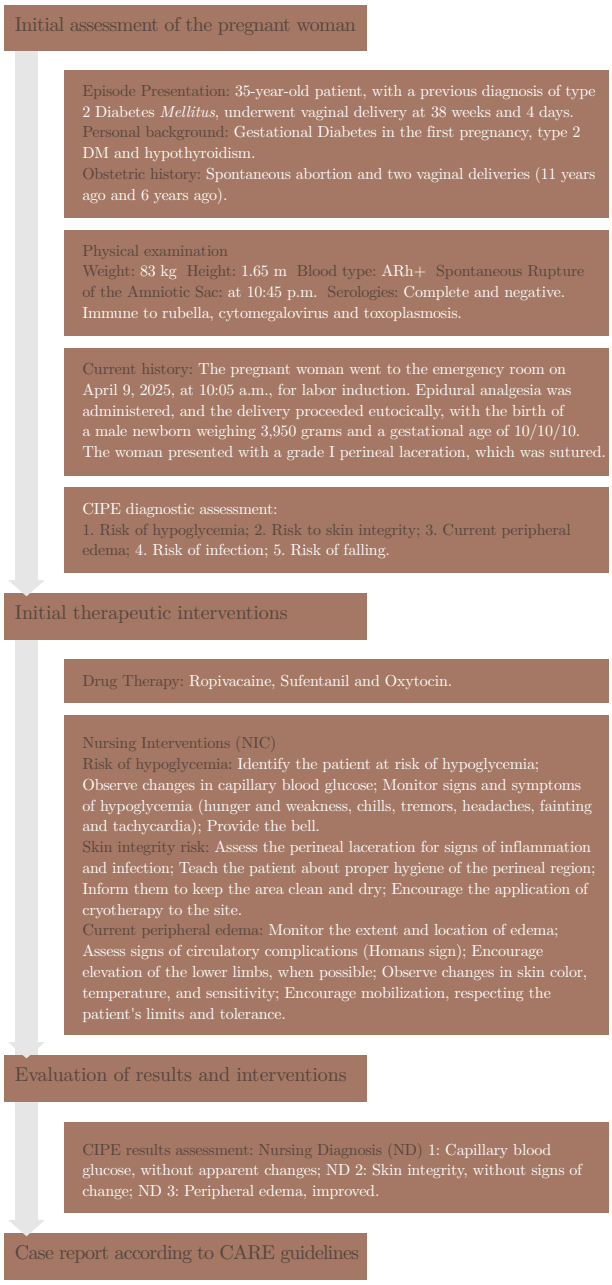


Figure 1: Case Report Flowchart.

# Results

Based on the analysis and interpretation of the data presented above, five nursing diagnoses (ND's) were defined. Among them, the following stand out as priorities: 1. Risk for hypoglycemia; 2. Risk to skin integrity; 3. Current peripheral edema, considered relevant in the context of type 2 DM. Resolution of these diagnoses is essential, as it significantly contributes to the improvement of the others. The care plan developed for each ND is described in Tables 2, 3, and 4.

**Table 2: Care plan – Risk of hypoglycemia.**

**OF 1. Risk of hypoglycemia:** "Compromised Regulatory System Process"(2010 version).

**Focus:** Hypoglycemia.
**Judgment:** Risk. According to the CIPE (2010 version), risk is defined as "Potentiality: Existing in possibility, risk".

**Nursing interventions:**
- Identify the user at risk of hypoglycemia;
- Observe changes in capillary blood glucose;
- Monitor for signs and symptoms of hypoglycemia (hunger and weakness, chills, tremors, headache, fainting and tachycardia);
- Provide the bell.

**Expected results:** Maintain blood glucose levels within normal parameters, preventing episodes of hypoglycemia.
**Results obtained:** Capillary blood glucose, without apparent changes.

**Final assessment:** Stable capillary blood glucose values. During hospitalization, none of the symptoms of hypoglycemia or the risk of its occurrence were detected.

**Table 3: Care plan – Skin integrity risk.**

**OF 2. Skin integrity risk:** "Integrity" (2010 version).

**Focus:** Skin integrity.
**Judgment:** Risk. According to the CIPE (2010 version), risk is defined as "Potentiality: Existing in possibility, risk".

**Nursing interventions:**
- Assess the perineal laceration for signs of inflammation and infection;
- Teach the user about proper hygiene of the perineal region;
- Inform to keep the area clean and dry;
- Encourage the application of cryotherapy on site.

**Expected results:** The user is expected to maintain good hygiene in the perineal region, promoting proper healing of the laceration and preventing signs of infection.
**Results obtained:** Skin integrity, no signs of alteration.

**Final assessment:** During her hospitalization, the patient maintained adequate perineal hygiene, demonstrating understanding and adherence to the instructions provided. The wound from the grade I perineal laceration evolved favorably, with no signs of infection, inflammation, or other complications. Adequate healing and no significant pain were observed.

**Table 4: Care plan – Current peripheral edema.**

**OF 3. Current peripheral edema:** "Fluid Retention: Condition of excessive accumulation of organic fluids in the tissue spaces; fluid retention with swelling of the peripheral tissues of the lower limbs in the standing position, swelling of the lumbar region in the supine position, central edema accompanied by shallow breathing, changes in the respiratory pattern or abnormal respiratory sounds" (2010 version).

**Focus:** Peripheral edema
**Judgment:** Current. According to CIPE (2010 version), Actual is defined as "Potentiality: Present or real".

**Nursing interventions:**
- Monitor the extent and location of edema;
- Assess signs of circulatory complications (homans sign);
- Encourage elevation of the lower limbs when possible;
- Observe changes in skin color, temperature and sensitivity;
- Encourage mobilization, respecting the user's limits and tolerance.

**Expected results:** Reduction of edema in the lower limbs throughout the hospital stay.
**Results obtained:** Peripheral edema, improved.

**Final assessment:** A slight reduction in edema in the lower limbs was observed, with improved comfort and mobility. Measures to elevate the limbs and encourage movement were implemented, with negative results. During hospitalization, the patient responded well to instructions and showed no signs of associated circulatory complications. The Homans sign was performed, with a negative result.

# Episode report

This case study involves a 35-year-old atheist patient who is married and currently works as an administrative technician. Her obstetric index was 2012, with a gestational age of 38 weeks and 4 days, and her blood type was Rh-positive, with negative serology and a negative beta-streptococcus test.

The pregnant woman went to the emergency room on April 9, 2025, at 10:05 a.m., for labor induction. Upon admission, the pregnant woman was awake, oriented, and well-disposed. Her vital signs were stable. She denied pain. A peripheral venous catheter was placed. A cardiotocography (CTG) was performed, revealing well-being fetal development and regular contractility. The remainder of the hospitalization protocol was initiated. AD requested an epidural, and an anesthesiologist was contacted.

At 10:45 p.m., the amniotic sac ruptured spontaneously, with clear amniotic fluid leaking and a 3 cm dilation of the cervix.

At 11:30 pm, complete dilation was observed, and the pregnant woman was transferred to the Delivery Room.

At 11:46 p.m., a vaginal delivery occurred, resulting in the birth of a male newborn weighing 3950 grams and with an Apgar score of 10/10/10.

Pregnant woman transferred to postpartum ward. Upon arrival, she was awake, oriented, calm, and hemodynamically stable. Her breasts were soft. The uterus was well contracted and infraumbilical. The perineum had a sutured grade I laceration, which she applied ice. Vaginal discharge had decreased (Source: Glintt System).

# Discussion

In the case studied, the patient was diagnosed with Gestational Diabetes (GD) during her first pregnancy, a condition that resolved postpartum but recurred during her second pregnancy. Subsequently, her blood sugar levels remained consistent with prediabetes and were monitored and controlled through diet and oral antidiabetic medication at home, specifically metformin 500 mg orally at breakfast and dinner. During the current pregnancy, insulin therapy with long-acting insulin, administered at night, was necessary to ensure adequate glycemic control.

GD refers to any alteration in glucose metabolism identified for the first time during pregnancy, regardless of whether insulin treatment is required[13]. This condition represents the body's response to the metabolic overload characteristic of pregnancy, especially in cases where associated risk factors exist, such as excess weight, a family history of diabetes, or a previous pregnancy with fetal macrosomia.

Diagnosis is usually made between 24 and 28 weeks of gestation, using a 75 grams glucose PTGO. The criteria defined for the diagnosis of GD, according to the Directorate-General for Health[14], consider the diagnosis positive if at least one of the following values is found:

a) Fasting blood glucose ≥ 92 mg/dL (5.1 mmol/L);

b) Blood glucose 1 hour after ingestion ≥ 180 mg/dL (10.0 mmol/L);

c) Blood glucose 2 hours after ingestion ≥ 153 mg/dL (8.5 mmol/L).

Adequate control of maternal glucose levels is essential, as elevated levels are associated with an increased risk of both maternal and neonatal complications. Risks for newborns include fetal macrosomia, large-for-gestational-age (LGA) fetuses, obstetric trauma, neonatal hypoglycemia, jaundice, and respiratory problems. Furthermore, these children have an increased risk of developing obesity and glucose metabolism disorders later in life[15].

For the mother, complications include a higher risk of cesarean delivery, preeclampsia, and a significantly increased risk of developing type 2 Diabetes in the years following delivery. Clinical follow-up after birth is essential for the prevention and early detection of future metabolic changes[16].

In this case, the patient, because it was her third pregnancy and she had previous experience with diabetes, demonstrated knowledge of the condition and the necessary care, particularly blood glucose monitoring using a glucometer, with assessments performed before main meals. However, during her hospital stay, it was not possible to fully comply with the service's internal protocol regarding blood glucose monitoring, which requires rigorous assessments at specific times to ensure the postpartum woman's glycemic stability and prevent potential complications.

Furthermore, due to the maternal diagnosis of type 2 DM and the newborn's LGA status, a neonatal glycemic monitoring protocol was implemented. This protocol includes capillary blood glucose assessments every 6 hours during the first 12 hours of life to identify hypoglycemic episodes early and ensure timely intervention. During hospitalization, the newborn followed the monitoring protocol, maintaining blood glucose levels within normal and appropriate ranges.

The treatment of GD is primarily based on the adoption of appropriate nutritional therapy, which should be personalized, considering the pregnant woman's nutritional status, eating habits, and medical history. If glycemic goals are not achieved within one to two weeks of starting this approach, the introduction of pharmacological therapy should be considered[17].

DG, as a condition transient, however, with potential lasting repercussions, it requires increased attention from healthcare professionals. Beyond diagnosis and treatment, it is essential to understand the impact of this condition on the health of the woman and newborn, both in the short and long term[18]. In the clinical context observed, the importance of close monitoring and personalized interventions capable of minimizing risks and promoting maternal and fetal well-being was evident.

Although the diagnostic criteria are well-defined, the practical approach requires the ability to adapt to the specificities of each case. In this sense, the nursing team's intervention proved crucial, not only in monitoring blood glucose levels but also in educating the patient and promoting healthy behaviors, essential aspects for metabolic control and preventing complications. However, in this specific case, despite adequate monitoring by the nursing team, intensive intervention was not necessary. The postpartum woman, in her third pregnancy and with a previous history of type 2 Diabetes *Mellitus*, demonstrated adequate knowledge about managing her health condition. She demonstrated knowledge of the necessary care, correctly monitored her blood glucose levels, and followed the meal plan independently.

This fact highlights the importance of prior experience and patient self-care training, reinforcing the idea that health education plays a lasting and ongoing role, with a positive impact on future clinical experiences. Even so, it is necessary to reflect on the increased risks this condition poses postpartum and in future pregnancies, as well as in the development of chronic diseases such as type 2 Diabetes. This perspective reinforces the importance of medium and long-term follow-up plans, promoting continuity of care even after hospital discharge.

Therefore, managing GD goes beyond monitoring laboratory values; it is an opportunity to intervene early, with a global view of maternal and neonatal health, promoting better results in the short, medium, and long term.

# Conclusion

The development of this Case Report proved to be a fundamental learning tool, enabling the articulation of academia with professional practice and strengthening evidence-based practice with continuous critical reflection. Through implicit clinical reasoning, it was possible to both make informed decisions and share experiences from daily practice.

In this context, it can be concluded that nursing intervention plays a fundamental role in the surveillance and monitoring of postpartum women with type 2 DM, contributing to the prevention of complications and the promotion of a safe and effective recovery. Strict monitoring of blood glucose levels, combined with monitoring of nutritional status, elimination patterns, and skin integrity, allows for an individualized, patient-centered approach.

The unit where this hospitalization took place has a specific protocol for monitoring pregnant and postpartum women with type 2 DM, which includes coordination between the nursing team and obstetricians. This protocol includes systematic assessment of capillary blood glucose levels, adjustment of antidiabetic therapy as prescribed by the physician, and the promotion of health education, focusing on self-care and adherence to the therapeutic regimen. The guidelines are organized in the unit's clinical practice manual, which promotes the standardization of care and enhances patient safety.

Furthermore, the nurse's educational role is essential, even when the patient already has prior knowledge of the condition, ensuring continuity of care after hospital discharge. Awareness of warning signs, the importance of metabolic monitoring, and dietary and physical activity care are reinforced during hospitalization.

In short, the adoption of well-structured protocols, combined with ongoing training of healthcare teams, is crucial to ensuring quality care, reducing complications associated with type 2 Diabetes, and promoting maternal health in the postpartum period.

### Implications for Nursing Practice

DM during pregnancy requires close monitoring and follow-up to ensure maternal and fetal well-being and healthy transitions during childbirth and the postpartum period. Continuous monitoring, complication prevention, and enhanced self-care contribute to metabolic stabilization and the woman's physical and emotional well-being.

Therefore, there is a growing need for focused health monitoring during pregnancy, ensuring recommended screenings and tailoring care to the needs of women with DM 2.

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Corresponding Author/Autor Correspondente
Susana do Vale – Unidade Local de Saúde do Norte Alentejano EPE: Portalegre, Portalegre, Portugal.
*susana.delgadinho@uevora.pt*

Authors' contributions/Contributo das Autoras
JL: Study coordination, study design, data collection, storage and analysis, review and discussion of results.
SV: Coordination of the study, review and discussion of the results.
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