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# Hypoglycemia Transition & follow-up

Adult Health Nursing | Transition & follow-up

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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: Sweating, shakiness and difficulty concentrating after delayed food.

Objective findings and required checks: Low bedside glucose with symptoms; swallowing and consciousness must be assessed.

Physical examination and investigations: Confirm bedside glucose promptly and repeat according to the emergency pathway; review cause and medicines.

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

## Clinical focus and pathophysiology

Hypoglycemia: Glucose supply is insufficient relative to treatment, intake or metabolic demand.

## Medical / surgical management

Follow the local hypoglycemia protocol using a safe route based on consciousness and swallowing; reassess recurrence risk.

## Illustrative drug and treatment study



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| Medicine / treatment | Purpose | Nursing checks |
| --- | --- | --- |
| Prescribed oral fast-acting glucose | Treat an alert patient able to swallow safely | Recheck glucose and follow the recovery plan |
| prescribed IV glucose or glucagon | Emergency treatment when indicated | Use the authorized route and monitoring. |

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: Check unresolved risks, medicine reconciliation, practical support and follow-up before transition.

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 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: Before any clinically approved transition: 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. 4. Follow the local hypoglycemia protocol using a safe route based on consciousness and swallowing; reassess recurrence risk. Rationale: Glucose supply is insufficient relative to treatment, intake or metabolic demand. 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 directly about safety, self-harm, aggression and access to harmful means. Assess: Assess risk, observation needs and environmental hazards collaboratively. | Immediate safety needs during altered mood, cognition or behaviour. Possible factors: reduced judgment, severe distress or loss of control. Validate against the patient's assessment. | Short-term: Before any clinically approved transition: Immediate risks are addressed using the least restrictive appropriate care plan. Longer-term: Before the clinically approved transition or agreed follow-up: A collaborative safety and follow-up plan is documented before transition. | 1. Escalate imminent danger immediately and maintain observation according to risk and local policy. Rationale: Timely support protects life and prevents unobserved deterioration. 2. Use de-escalation, respectful communication and proportionate environmental safeguards. Rationale: Dignity and reduced stimulation can support safer engagement. 3. Review risk with the multidisciplinary team and document changes and handover. Rationale: Risk is dynamic and requires continuity across staff and settings. | 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 worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions. | Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment. | Short-term: Before any clinically approved transition: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care. | 1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance. | 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 understand. Assess: | Learning needs about the condition and care plan. Possible factors: new | Short-term: Before any clinically approved transition: Explains the most important immediate | 1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few | Record the baseline and reassessed finding, the time |



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| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Use teach-back or demonstration to identify specific gaps. | information, complex treatment or limited prior teaching. Validate against the patient's assessment. | 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. | 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 symptom recognition, carrying appropriate rescue treatment, meal planning and medication review. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care. | 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 symptom recognition, carrying appropriate rescue treatment, meal planning and medication review.

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

**Reduced consciousness, seizure, inability to swallow or persistent low glucose requires emergency help.**

## 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

- Glucose supply is insufficient relative to treatment, intake or metabolic demand.

- Priority concerns: Blood glucose instability requiring close monitoring; Immediate safety needs during altered mood, cognition or behaviour; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- Reduced consciousness, seizure, inability to swallow or persistent low glucose requires emergency help.

- Teach symptom recognition, carrying appropriate rescue treatment, meal planning and medication review.

**Exam / viva: Which unresolved problem would delay transition, and what information must reach the next care team?**

## References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
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