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Blood glucose instability requiring close monitoring Hypoglycemia

Adult Health Nursing | Focused diagnosis-based template

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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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Focused nursing-problem template

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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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: At the next patient-specific reassessment: 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Health Alterations - Open RN / WisTech Open, 2025
https://wtcs.pressbooks.pub/healthalts/

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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

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