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Immediate safety needs during altered mood, cognition or behaviour 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 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: At the next patient-specific reassessment: 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. 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: Immediate safety needs during altered mood, cognition or behaviour.
- 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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