

V-Sim: Skyler Hansen

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NUR 393

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## Medical Case 5: Skyler Hansen

### Guided Reflection Questions

- How did the scenario make you feel?  
This scenario made me feel that it is crucial to offer prompt and precise experiencing hypoglycemia. It is also important to monitor the patient's blood sugar frequently to make sure it is stable and to provide medications. I felt as though I was faced with a real-life scenario where it was imperative for me to deliver safe and accurate care to Mr. Skyler in order to prevent the situation from worsening.
- What management options would have been appropriate if Skyler Hansen had been alert and could swallow?  
If Skyler Hansen was alert and could swallow, a few management options would have been appropriate, such as; providing a snack, hard candies, fruit juice (orange juice), regular soda, non-diet soft drinks, 2 to 3 tablespoons of sugar or honey, glucose gel or tablets.
- If Skyler Hansen's acute hypoglycemic episode had not have been treated immediately, what could have happened?  
If Skyler Hansen's acute hypoglycemic episode had not have been treated immediately, this would probably lead to confusion, disorientation, impaired cognitive function, and seizure. If it becomes severe, it could cause unconsciousness, coma and could also lead to death.
- If too much glucose were administered to Skyler Hansen while the health care team was trying to correct his blood glucose level, what could occur?  
If too much glucose were administered to Skyler Hansen while the health care team was trying to correct his blood glucose level, this would lead to hyperglycemia, neuropathy and nerve damage.
- What key elements would you include in the handoff report for this patient? Consider the SBAR (situation, background, assessment, recommendation) format.

Situation: The patient named is Skyler Hansen and he had an episode of hypoglycemia.

Background: He is 18-year-old male, he lives with his family, he has no known allergy, he had not eaten for at least 5 hours, he was acting irrational with slurred speech.

Assessment: Obtain Vital signs, Patient has no pain complaint, he is alert and oriented x4, respiratory rate 12, T= 98.0 °C, BS= 102mg/dl, 50% dextrose in water was administered IV, 3-lead ECG showed sinus rhythm.

Recommendation: Check BS level every hour, assess if patient doesn't need nasal oxygen, follow up with provider for plan of care, follow up on patient education.

- Describe age-appropriate patient teaching for Skyler Hansen and resources that may be helpful to him.

- Skyler Hanse should receive education on his current illness, including symptoms, causes and preventive measures to avoid experiencing another hypoglycemic episode.
- Patient should understand the repercussions of skipping meals and is should be urged to carry snacks or hard candy when participating in physical activity. He should also follow a healthy eating plan.
- The patient should receive different type of resources to help him manage the disease.
- Additionally, Skyler should learn how to use a glucometer and should frequently monitor his blood sugar level.
- Lastly, encourage patient to wear medical identification bracelet with indication. Patient should also go to follow-up appointments.

7. Discuss confidentiality and legal empowerment of 18-year-old patients such as in Skyler Hansen's case.

Skyler is considered as an adult, therefore, he has the right to privacy and confidentiality with regard to his healthcare information. Before sharing his information, his consent should be obtained. Because of his age, he has the legal right to make his own decisions regarding the treatments, care, and medications he will receive. Per consequent, his autonomy should not be violated.

8. What would you do differently if you were to repeat this scenario? How would your patient care change?

If I were to repeat this scenario, I would focus more on providing nursing interventions. I would make sure I check his blood glucose frequently and provide more education to Skyler regarding the disease.

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### Documentation Assignments

1. Document your focused assessment for Skyler Hansen.  
Skyler Hansen heart rate is 95, pedal and radial pulse are present and strong. Respiratory rate is 20 breaths per minute. Patient blood pressure is 128/77 mm Hg. SpO<sub>2</sub> is 97% and his temperature is 98.6°F (37.0°C). Blood glucose is 56mg/dl (3.1mmol/L). There is normal elasticity of the skin. His sin is dry with normal color and temperature.
2. Identify and document key nursing diagnoses for Skyler Hansen.  
Risk for deficient fluid volume, deficient knowledge, risk for disturbed sensory perception, imbalanced nutrition, risk for injury
3. Document Skyler Hansen's blood glucose levels that occurred in the scenario.  
At arrival the patient's blood glucose was 56mg/dl. However, after the administration of 50 ml of dextrose in water and the ingestion of carbohydrates and proteins, Skyler's blood glucose increase to 110mg/dl. A few minutes later, the blood sugar level remained the same (110mg/dl).
4. Document the changes in Skyler Hansen's vital signs and clinical manifestations of hypoglycemia throughout the scenario.  
Heart rate: 93  
Respiratory rate: 20  
Blood pressure: 128/77 mm Hg  
SpO<sub>2</sub>: 97%  
Temperature: 98.6°F (37.0°C)  
  
Heart rate: 94  
Respiratory rate: 20  
Blood pressure: 130/77 mm Hg  
SpO<sub>2</sub>: 97%  
Temperature: 98.6°F (37.0°C)  
  
Heart rate: 95  
Respiratory rate: 20  
Blood pressure: 131/78 mm Hg  
SpO<sub>2</sub>: 96%  
Temperature: 98.6°F (37.0°C)  
  
Heart rate: 96  
Respiratory rate: 20  
Blood pressure: 131/78 mm Hg  
SpO<sub>2</sub>: 96%  
Temperature: 98.6°F (37.0°C)

Heart rate: 97  
Respiratory rate: 20  
Blood pressure: 130/77 mm Hg  
SpO<sub>2</sub>: 95%  
Temperature: 98.6°F (37.0°C)

Heart rate: 98  
Respiratory rate: 12  
Blood pressure: 132/79 mm Hg  
SpO<sub>2</sub>: 95%  
Temperature: 98.6°F (37.0°C)

Heart rate: 87  
Respiratory rate: 12  
Blood pressure: 128/76 mm Hg  
SpO<sub>2</sub>: 96%  
Temperature: 98.6°F (37.0°C)

Heart rate: 86  
Respiratory rate: 12  
Blood pressure: 126/75 mm Hg  
SpO<sub>2</sub>: 96%  
Temperature: 98.6°F (37.0°C)

Heart rate: 85  
Respiratory rate: 12  
Blood pressure: 122/73 mm Hg  
SpO<sub>2</sub>: 96%  
Temperature: 98.6°F (37.0°C)

- Referring to your feedback log, document the nursing care you provided.  
I introduced myself  
I washed my hands  
I identified the patient  
I obtained the vital signs of the patient and assessed his breathing pattern.  
I attached the pulse oximeter to monitor the oxygen level  
I checked the blood glucose level of the patient and I called the provider.  
After receiving the orders from the provider, I obtained an IV access in the arm, flushed the cannula, asked about medication allergies, verified the order with another nurse, compared the medication label with MAR, administered 50 ml of IV dextrose in water. Before administering the 1mg of glucagon ordered by the provider, I again asked the patient about medication allergies, verified the order with another nurse, compared the medication label with MAR.  
Afterwards, I checked his radial pulse & pedal pulses bilaterally, I checked his blood sugar again and took a venous blood sample.

I asked patient if he is allergic to anything, I compared the medication label with the MAR. I started a 100ml infusion of normal saline 50 mL/h , then, I flushed the cannula. I attached a 3-lead ECG.

I assessed the patient's IV site for redness, swelling, infiltration, bleeding or drainage.

I attached the automatic non-invasive blood pressure to patient.

I listened to the heart sound then to the lungs sound.

I checked the patient's radial and pedal pulse and obtained his vital signs once gain.

I sat the patient up and gave him proteins and carbohydrates orally.

I provided patient education

At the end, a patient handoff was perform.