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Epilepsy care Initial assessment

Adult Health Nursing | Initial assessment

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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.

Patient profile and history

26-year-old woman with known epilepsy after a breakthrough seizure. Care stage: At the first supervised assessment.

Medical history: Known epilepsy is treated with prescribed antiseizure medicine. The patient reports missing a dose before this breakthrough event. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Reports a missed dose and feeling tired after the event.

Objective findings and required checks: Recovering consciousness with ongoing observation; injury assessment is needed.

Physical examination and investigations: Document seizure description and duration; review glucose, electrolytes, medicine history and tests ordered by the team.

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

Clinical focus and pathophysiology

Epilepsy care: Abnormal synchronized neuronal activity can cause recurrent seizures and temporary impaired awareness.

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Medical / surgical management

Protect from injury, assess airway and recovery, and follow the individualized emergency and medication plan.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed antiseizure medicine	Reduce recurrence	Verify regimen, adherence, interactions and adverse effects
prescribed rescue medicine	Treat qualifying prolonged or repeated seizures	Use only the authorized emergency protocol and monitoring.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Reports a missed dose and feeling tired after the event. Recovering consciousness with ongoing observation; injury assessment is needed. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize vulnerability to injury during seizure activity; vulnerability to a fall or accidental injury; emotional distress affecting participation in care; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Protect from injury, assess airway and recovery, and follow the individualized emergency and medication plan. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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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: 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 warning symptoms, seizure history and prescribed treatment. Assess: Observe consciousness, seizure features, duration and recovery.	Vulnerability to injury during seizure activity. Possible factors: altered neurological activity or the underlying condition. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: The patient is protected from avoidable injury and urgent prolonged activity is escalated. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized seizure first-aid and follow-up plan.	1. Time and describe seizure activity and call for urgent help according to protocol. Rationale: Duration and recovery help identify an emergency. 2. Protect from nearby hazards, avoid restraint and place nothing in the mouth. Rationale: These actions reduce avoidable trauma and airway obstruction. 3. Support airway assessment, appropriate recovery positioning and prescribed emergency care. Rationale: Breathing and circulation may be compromised during or after a seizure. 4. Protect from injury, assess airway and recovery, and follow the individualized emergency and medication plan. Rationale: Abnormal synchronized neuronal activity can cause recurrent seizures and temporary impaired awareness. 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 about falls, dizziness, vision and usual walking aids. Assess: Assess gait, medicines, cognition and environmental risks.	Vulnerability to a fall or accidental injury. Possible factors: unsteady mobility, dizziness or environmental hazards. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Transfers and essential activity occur without a fall during the care period. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates safe use of assistance and identifies home hazards.	1. Individualize fall precautions and keep necessary items and the call bell accessible. Rationale: Accessible support reduces unsafe unassisted movement. 2. Supervise transfers according to assessed need and check footwear and aids. Rationale: Correct assistance and equipment improve stability. 3. Review reversible contributors with the team, including postural symptoms and medicines. Rationale: Addressing causes improves safety beyond environmental measures.	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: After the first indicated intervention, at the documented review time: 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: After the first indicated intervention, at the documented review time:	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.	Explains the most important immediate 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 adherence, trigger management, safe first aid and individualized activity and driving advice under applicable rules. 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 adherence, trigger management, safe first aid and individualized activity and driving advice under applicable rules.

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

A prolonged seizure, repeated seizures without recovery, injury or breathing difficulty is an emergency.

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

- Abnormal synchronized neuronal activity can cause recurrent seizures and temporary impaired awareness.

- Priority concerns: Vulnerability to injury during seizure activity; Vulnerability to a fall or accidental injury; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- A prolonged seizure, repeated seizures without recovery, injury or breathing difficulty is an emergency.

- Teach adherence, trigger management, safe first aid and individualized activity and driving advice under applicable rules.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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