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Pre-eclampsia Initial assessment

Midwifery & O.G. 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

29-year-old pregnant woman after 20 weeks with suspected pre-eclampsia. Care stage: At the first supervised assessment.

Medical history: Fictional obstetric history: G1P0 at 34 weeks. New hypertension with headache/visual symptoms prompted urgent assessment for pre-eclampsia and organ involvement. 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 woman requests respectful explanation and involvement of her chosen support person with consent. Assess access to maternity follow-up, nutrition, transport and infant-care support.

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

Clinical assessment

Subjective: Persistent headache and visual disturbance.

Objective findings and required checks: Raised blood pressure with clinical assessment for proteinuria and organ involvement.

Physical examination and investigations: Review repeated blood pressure, urine protein, blood count/platelets, renal/liver tests and fetal assessment.

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

Clinical focus and pathophysiology

Pre-eclampsia: Pregnancy-associated endothelial and placental dysfunction can affect multiple maternal organs and fetal well-being.

Medical / surgical management

Escalate promptly, monitor maternal/fetal status and prepare prescribed antihypertensive, seizure-prevention and birth-planning care.

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Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed antihypertensive	Control clinically significant hypertension	Monitor pressure and adverse effects
prescribed magnesium sulfate when indicated	Prevent or treat eclamptic seizures	Monitor respiration, reflexes and urine according to protocol.

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

Nursing process - ADPIE

Assessment

Persistent headache and visual disturbance. Raised blood pressure with clinical assessment for proteinuria and organ involvement. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize reduced circulation to vulnerable tissues; vulnerability to injury during seizure activity; 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

Escalate promptly, monitor maternal/fetal status and prepare prescribed antihypertensive, seizure-prevention and birth-planning care. 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 dizziness, chest discomfort, fatigue and cold extremities. Assess: Assess consciousness, pulse, blood pressure, capillary refill and urine trend.	Reduced circulation to vulnerable tissues. Possible factors: altered blood flow or cardiac function. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Circulation and consciousness remain within the clinician-agreed targets. Longer-term: Before the clinically approved transition or agreed follow-up: Describes symptoms that require immediate review and the agreed follow-up plan.	1. Trend perfusion findings and escalate new chest pain, shock or altered consciousness immediately. Rationale: Poor circulation can rapidly threaten organ function. 2. Balance activity and rest and maintain the ordered monitoring schedule. Rationale: Reducing demand supports recovery while trends guide treatment. 3. Administer prescribed therapy and monitor effects and adverse reactions. Rationale: Response monitoring supports safe correction of the underlying problem. 4. Escalate promptly, monitor maternal/fetal status and prepare prescribed antihypertensive, seizure-prevention and birth-planning care. Rationale: Pregnancy-associated endothelial and placental dysfunction can affect multiple maternal organs and fetal well-being. 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 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.	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.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: 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.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few 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. Explain monitoring, medicine safety, fetal assessment and postpartum warning signs. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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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Health education and continuing care

Explain monitoring, medicine safety, fetal assessment and postpartum warning signs.

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

Seizure, severe headache/visual change, epigastric pain, breathing difficulty or reduced consciousness requires emergency maternity response.

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

- Pregnancy-associated endothelial and placental dysfunction can affect multiple maternal organs and fetal well-being.

- Priority concerns: Reduced circulation to vulnerable tissues; Vulnerability to injury during seizure activity; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- Seizure, severe headache/visual change, epigastric pain, breathing difficulty or reduced consciousness requires emergency maternity response.

- Explain monitoring, medicine safety, fetal assessment and postpartum warning signs.

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

References

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