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# Vulnerability to injury during seizure activity Eclampsia emergency nursing

Midwifery & O.G. 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: Prior headache or visual symptoms may be reported by family.

Objective findings and required checks: Seizure and impaired consciousness require immediate airway and maternity emergency assessment.

Physical examination and investigations: Assess airway, breathing, circulation, seizure duration, blood pressure and ordered maternal/fetal investigations.

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

## Clinical focus and pathophysiology

Eclampsia emergency nursing: Severe pregnancy-associated disease can produce seizures and threaten maternal and fetal life.

## Medical / surgical management

Activate emergency maternity care, protect from injury and support the prescribed seizure, blood-pressure and birth plan.



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## Illustrative drug and treatment study

| Medicine / treatment | Purpose | Nursing checks |
|---|---|---|
| Magnesium sulfate as prescribed | Treat and prevent recurrent eclamptic seizures | Monitor protocol-defined toxicity signs and readiness for authorized reversal |
| prescribed antihypertensive | Manage severe hypertension | Monitor the ordered targets. |

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 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: At the next patient-specific reassessment: 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. Activate emergency maternity care, protect from injury and support the prescribed seizure, blood-pressure and birth plan. Rationale: Severe pregnancy-associated disease can produce seizures and threaten maternal and fetal life. 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

After stabilization explain ongoing postpartum monitoring, follow-up and recurrence-related counseling.

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

**Recurrent seizure, respiratory depression, shock or reduced consciousness requires immediate senior emergency support.**

## 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

- Severe pregnancy-associated disease can produce seizures and threaten maternal and fetal life.
- Priority concerns: Vulnerability to injury during seizure activity.
- Recurrent seizure, respiratory depression, shock or reduced consciousness requires immediate senior emergency support.
- After stabilization explain ongoing postpartum monitoring, follow-up and recurrence-related counseling.

**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/

Maternal-Newborn Nursing: external further reading - OpenStax / Rice University
https://openstax.org/books/maternal-newborn-nursing/pages/preface



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