NGN NCLEX • 2026 | PEDIATRIC FOCUS

PEDIATRIC SEIZURES

High-Yield Rapid Review • Assessment • Interventions • Safety • Meds • Family Education

WHAT IS A SEIZURE?

A **sudden, uncontrolled electrical disturbance** in the brain causing changes in behavior, movement, sensation, or consciousness. In children, causes include **fever, epilepsy, trauma, infection (meningitis), electrolyte imbalance (↓Na^+, ↓glucose), or genetic disorders.**

1 TYPES OF PEDIATRIC SEIZURES

Febrile

6 mo – 5 yr

Trigger: rapid ↑ temp (≥38°C/100.4°F). **Most common** seizure in children. Usually benign; genetic predisposition.

Tonic-Clonic

Any age

Tonic: stiffening, LOC. **Clonic:** rhythmic jerking. Tongue biting, incontinence, **postictal sleep/confusion.**

Absence (Petit Mal)

4 – 12 yr

Brief (5–30 sec) staring spells, blinking, no postictal. Often mistaken for **daydreaming/ADHD**. May occur 100+ ×/day.

Infantile Spasms

3 – 12 mo

West syndrome. Sudden flexion/extension ("salaam" attacks). **EEG: hypsarrhythmia.** Medical emergency → refer!

Focal (Partial)

Any age

One hemisphere. **Simple:** awake. **Complex:** altered awareness, automatisms (lip smacking). May have **aura.**

Atonic / Myoclonic

Any age

Atonic: "drop attacks" — sudden tone loss (**helmet!**). **Myoclonic:** brief lightning jerks of muscle groups.

2 FEBRILE SEIZURE DEEP DIVE ★ VERY HIGH YIELD

Simple vs. Complex Febrile Seizure

✓ SIMPLE (typical)

- Duration **< 15 minutes**
- **Generalized** (whole body)
- **Only 1** seizure in 24 hrs
- No neuro deficit after
- Low risk → reassurance

⚠ COMPLEX (red flags)

- Duration **> 15 minutes**
- **Focal** (one side)
- **≥2 seizures** in 24 hrs
- Postictal deficit (Todd paralysis)
- Workup: labs, LP, imaging

3 NURSING PRIORITIES: DURING & AFTER

★ DURING THE SEIZURE

- ✓ **SAFETY FIRST** — stay with child, call for help
- ✓ Place child on **SIDE** (lateral) — prevent aspiration
- ✓ Protect head with soft item; **clear area** of hard objects
- ✓ Loosen tight clothing around neck
- ✓ **TIME** the seizure; note type & behavior
- ✓ Suction PRN; apply O_2 if available
- ✓ Maintain IV access for emergency meds

AFTER (POSTICTAL)

- ✓ Maintain **SIDE-LYING** recovery position
- ✓ Assess **ABCs** → airway, breathing, circulation
- ✓ VS + pulse ox + neuro/LOC check
- ✓ Expect drowsiness, confusion, ↓LOC — allow rest
- ✓ Orient gently, reassure child and family
- ✓ **Document:** onset, duration, movements, postictal
- ✓ Check for injury, incontinence, tongue trauma

4 DO'S & DON'TS (BOARDS LOVE THESE!)

DO

- Turn child to **side** to prevent aspiration
- Protect the **head** with padding
- **Time** the seizure & describe movements
- Stay calm; stay with the child
- Loosen restrictive clothing

DON'T

- × **Never restrain** the child's movements
- × **Nothing in the mouth** (no bite blocks!)
- × Do not give **food/fluids** during or immediately after
- × Do not leave the child unattended
- × Don't move child unless in danger

5 STATUS EPILEPTICUS — EMERGENCY!

STATUS EPILEPTICUS

Seizure > 5 minutes OR repeated seizures without return to baseline. → Airway, O_2, IV, glucose check, STOP the seizure!

1ST LINE	ALT / NO IV	2ND LINE
Lorazepam	**Diazepam**	**Fosphenytoin**
IV (Ativan)	IV or rectal	or Levetiracetam

6 LONG-TERM ANTISEIZURE MEDS — WATCH FOR!

Levetiracetam
(Keppra)
Mood/behavior changes, irritability, agitation. Few drug interactions.

Valproic Acid
(Depakote / Depakene)
Hepatotoxicity, pancreatitis, **teratogenic** (neural tube defects). Monitor LFTs.

Phenytoin
(Dilantin)
Gingival hyperplasia (oral care!), ataxia, therapeutic level **10–20 mcg/mL.**

Carbamazepine
(Tegretol)
Agranulocytosis, SJS (esp. HLA-B*1502+), monitor CBC.

Lamotrigine
(Lamictal)
Stevens-Johnson Syndrome — stop at first rash! Titrate slowly.

Phenobarbital
(neonatal 1st line)
Sedation, **paradoxical hyperactivity** in kids, respiratory depression.

7 FAMILY & CHILD EDUCATION

Empower the Family

- ★ **Never stop antiseizure meds abruptly**
- ★ **No unsupervised swimming or bathing**
- ★ **Keep a seizure diary — triggers & duration**
- ★ **Treat fever early (acetaminophen) in febrile kids**
- ★ **School plan / 504 — inform teachers & nurse**
- ★ **Medical ID bracelet at all times**
- ★ **Helmet for bikes, skating, or atonic type**
- ★ **Avoid triggers: sleep loss, stress, flashing lights**
- ★ **Ketogenic diet may be used for refractory cases**
- ★ **Driving restrictions for teens per state law**

8 WHEN TO CALL 911 / GO TO THE ED

⚠ EMERGENCY CRITERIA

- ☎ Seizure lasts **> 5 minutes**
- ☎ Repeated seizures without recovery
- ☎ Injury during seizure (head trauma)
- ☎ Known pregnancy or diabetes
- ☎ **First-ever** seizure
- ☎ **Difficulty breathing** or cyanosis after
- ☎ Seizure in **water** / suspected aspiration
- ☎ Does not return to baseline within ~1 hr

9 NGN NCLEX TEST-TAKING STRATEGY

NGN NCLEX TIP

CLINICAL JUDGMENT FOCUS: Peds seizure items often use **Bowtie, Drag-and-Drop, Matrix, and Highlight** formats. Always prioritize **airway & safety** first — side-lying position beats "call provider" every time during an active seizure.

KEY DECISION POINTS: (1) Is it *febrile* simple vs. complex? (2) Is this *status epilepticus*? (3) Which *medication adverse effect* is this? (4) What is the *priority nursing action*?

SIDE-LYING = #1 | TIME IT | NOTHING IN MOUTH | NEVER RESTRAIN | >5 MIN = STATUS | ABC → THEN MEDS