Title: **CARE OF PATIENTS WITH SEIZURES**

Purpose: To prevent injury to the patients during convulsive episode. To recognize and record the progression of symptoms. To maintain support to patient during seizure episode.

Practice Title: Assessing and Managing Patients Who Have Seizures

Responsibility: All trained Inpatient Behavioral Health staff

Equipment:

1. Special Report Sheet
2. Watch with second hand
3. Pillow
4. Blankets
5. Suction machine
6. Mask
7. Nasal cannula
8. Oxygen
9. Airway
10. BP cuff
11. Stethoscope
12. Flashlight
13. Thermometer

Procedure	Point of Emphasis
1. Obtain complete history of seizures including, age of onset aura (if any), type, frequency, duration, post-ictal stage, length of illness, when seizures occur, time of day, presence/absence of aura, triggering factors, current medication dosage (if any), and any past medications. Name of physician following seizure medications and origin (e.g., head injury, brain lesion), date and place of last EEG.	Use nursing admission assessment to obtain history.
2. Flag chart with seizure precautions and note seizure precautions on white board.	Flag with allergy alert tape on front cover of chart.
3. Assign room that is easily visible.	Avoid situations that could precipitate a seizure (blinking lights, fatigue).
4. Give medications as prescribed. Teach patient and family the importance of taking medication regularly as prescribed by physician. Inform patient to report any changes in vision, facial muscle weakness, skin rash, dizziness or convulsions, unusual bleeding (i.e., gums, nosebleeds, bruising), yellow eyes or skin to physicians. Educate patient to notify RN if aura occurs. Observe the child during the aura, (if reported), during the seizure activity and after the seizure.	Monitor temperature in a child with a fever, especially if the child has a history of febrile seizure; administer antipyretics as ordered. Monitor patient safety and monitor all signs/symptoms.
5. Institute protective measures. Keep hard objects out of bed. Pad headboard and dresser with bath blanket. Ensure that patient cannot fall out of bed, or place mattress on floor. Have suction machine and oxygen available.	Be sure patient is closely monitored at all times and placed on seizure precautions. Recommend the patient to shower and provide close supervision during grooming. Educate the teachers and/or other patient care staff to contact that staff if patient reports changes and /or is having a seizure.
6. Complete emergency actions during seizures. Remain with	Document thoroughly in medical chart.

Procedure

patient. Ease patient to the floor if standing; loosen clothing around patient's neck; turn patient to the side; if patient begins to vomit, turn patient to the side, remove eyeglasses, remove furniture from immediate area, put small blanket or pillow under head; suction as needed; give oxygen per physician's order. DO NOT give anything by mouth. After seizure, place patient in bed on side. Do not restrain during seizure.

7. Accurately record seizures /
   in the electronic medical record and include the following:
   - Time seizure started and ended and length of seizure in seconds.
   - Significant pre-seizure events (i.e., lethargy, noise, excitement).
   - Behavior, aura before seizure.
   - Type of movements observed (tonic, clonic).
   - Areas of the body involved.
   - Any incontinence.
   - Movements in eyes.
   - Change in pupil size.
   - Respiration changes.
   - Color changes.
   - Changes of consciousness.
   - Mouth/teeth clenched, movement, foaming
   - Behavior after seizure including memory weakness, pupil reaction, vital signs, unusual sensations.
   - Report all to physician
   - Time the post ictal period

Point of Emphasis

Activate EMS as directed.
Stay with the patient and offer reassurance until fully alert because the patient may be confused and frightened.

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References:

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