NURSING PRACTICE EXPECTATIONS OF CARE:

(formerly 101soc)

- This standard of care applies only to those patients admitted to the Epilepsy Monitoring Unit located on the 10th floor, Peter O. Kohler Pavilion, specifically for inpatient evoked seizure monitoring. For all other patients with known seizure disorders or who experience seizures while inpatients at OHSU, refer to the Adult Inpatient Seizure Precautions and Seizure Monitoring Standard of Care (51soc) (Archived: Refer to CPG).

STANDARD 1:

Assessment and Diagnosis - The nurse collects relevant health and seizure data and analyzes the data to determine diagnoses.

Assessment:

1. On admission to a seizure monitoring bed on KPV 10:
   A. Identify type and history of seizures.
   B. Neurological assessment on admission and Q 4 hours for duration of inpatient stay.
   C. Insure peripheral IV access with 20 gauge.
   D. Initiate Adult Inpatient Standard of Care.
   E. Provide colored linen on the bed to allow for contrast during video recording.

2. Assess neurological status during and immediately after a seizure, including:
   A. Neurological status and sedation level.
   B. Vital signs including respirations, O2 saturation, heart rate, and BP.
   C. Conduct seizure examination (see Attachment A).

3. Reassess Q 4 hours x 24 hours until stable, then Q 8 hours until returned to baseline. Assessment includes:
   A. Neurological status and sedation level.
   B. Respiratory and O2 saturation.
   C. Movement and sensation.
   D. Monitor patient's response to any medications given to stop or control the seizures.

Labs/Diagnostics:

1. Monitor ordered lab tests daily.

STANDARD 2:

Outcome Identification - The nurse identifies individualized expected outcomes for the patient

Expected Outcomes:

1. Seizure related injury is minimized.
2. The patient's seizure activity will be captured on video/audio tape and by EEG for analysis.

STANDARD 3:

Develop and Implement Plan of Care - The nurse develops and implements a plan of care to assist the patient in achieving expected outcomes.

Procedures/Treatments:

1. When a seizure occurs, stay with the patient, assess seizure activity and neurological status, and document observations:
   A. Presence of aura preceding the seizure
B. Eye and head deviation
C. Level of consciousness and changes in consciousness during the seizure
D. Arm and leg movement
E. Muscle tone and sensation
F. Ability to answer question
G. Ability to follow directions
H. Occurrence of incontinence
I. Length of time to return to baseline

2. If the patient is having generalized tonic-clonic seizure or having airway problems, immediately turn the patient on to their side and suction as needed. Do not force mouth open. Apply O2 via nasal cannula for oxygen saturations below 90%.

3. Record duration of seizure activity and any neurological changes that occur.

4. Stay with the patient until the seizure is over and patient is stable & able to protect their airway without difficulty.

   Note: If the patient is incontinent, clean up after the seizure is over

5. If Epilepsy Monitoring Unit (EMU) Sleep Deprivation Protocol is ordered:
   A. Patient is to remain awake until 4 am. Nurse is to check on patient periodically to make sure patient is awake. Family members can often help with this if available.
   B. Patient is allowed to sleep from 4 am until 6 am. The patient is to be woken up at 6 am.
   C. Patient is to remain awake until dinnertime the following day.

Nutrition/IVs:
1. Consult physician for administration of IV antiepileptic medications.

Medications:
1. Patients admitted to KPV 10 Epilepsy Monitoring Unit are weaned off their antiepileptic medications or have the doses significantly decreased, in an attempt to evoke seizures for analysis and diagnosis. In the event of a generalized tonic-clonic seizure, patients may be given Lorazepam (Ativan), or another antiepileptic medication, as ordered by the physician, if the patient is in danger of status epilepticus.

Activity/Safety:

   Note: The use of siderails for this patient population is with the intent to protect the patient from harm or injury during seizure activity as per CMS Conditions of Participation*.

1. Provide for patient safety at all times:
   A. Seizure pads placed on all bed rails.
   B. All four bed rails to remain up.
   C. Wall suction set-up in room with yankauer.
   D. Oxygen flow meter at bedside with oxygen tubing and nasal cannula attached
   E. Ambu bag at the bedside.
   F. Intubation tray at bedside.
   G. A turn sheet on the bed

2. During a seizure:
   A. Stay with the patient, move equipment, tray tables, water container, out of the way to protect the patient from injury.
   B. Ensure side rails, with seizure pads, are up.
   C. If airway is not clear, provide oral suction. If teeth are clenched, do not force anything into the mouth. (Do not use an oral airway).
   D. Turn patient onto their side to protect the airway.
   E. Provide oxygen for saturations below 90% or as otherwise ordered.

3. Following a seizure, keep patient on bed rest until awake and alert.

   Note: After a generalized tonic clonic seizure ("grand mal") seizure, the patient is likely to be sleepy for several hours and will need to be assessed frequently for safety and the potential for another seizure. The patient may also require Q 2 hour turning until awake and alert.

4. All patients must be accompanied when out of bed (e.g., going to the bathroom or up in a chair) by a KPV 10 RN.
5. Every seizure requires documentation on the Seizure Observation Sheet.

6. Seizure activity will require physician notification dependent on the seizure type and number of seizures. Nursing should follow these guidelines, including cases of non-epileptic events (psychogenic events or "pseudoseizures"). The treating M.D. may modify this protocol on a case-by-case basis if indicated. If the protocol is modified in any way by the M.D., it must be written as a physician order. In all instances, nursing care should be provided to the patient as stated in this Standard of Care.

A. Generalized Tonic Clonic Seizure
   1. Contact Neurology resident on call and ask them to assess patient
   2. Document event on the Seizure Observation Sheet

B. Complex Partial Seizure (seizure with alteration of consciousness)
   1. Contact Neurology resident if multiple or prolonged seizure activity
   2. Document event on Seizure Observation Sheet

C. Seizure without alteration of consciousness (simple partial or other)
   1. Contact Neurology resident to report repetitive or prolonged seizure activity.
   2. Document event on Seizure Observation Sheet

D. Multiple Seizures (3 or more seizures within 8 hours with full recovery between seizures)
   1. Contact Neurology resident on call and ask them to assess patient

E. Prolonged Seizures
   1. Non-Convulsive Status Epilepticus (single non-convulsive seizures lasting >5 minutes or a series of non-convulsive seizures without recovery lasting >30 minutes)
      a. Contact Neurology resident and ask them to assess patient
   2. Convulsive Status Epilepticus (single convulsive seizure lasting >5 minutes or series of convulsive seizures without recovery lasting >30 minutes)
      a. CALL CODE 99
      b. Provide immediate emergency nursing care to the patient Contact Neurology resident on call to IMMEDIATELY assess the patient

Note: If ANY PATIENT has an apneic period lasting two minutes, CALL CODE 99

Teaching/Discharge planning:

1. Teach patient and family or caregiver about safety while an inpatient on KPV 10? do not get out of bed without being accompanied by a KPV 10 RN.

2. Instruct patient and family or caregiver on the use of seizure monitoring equipment and use of nurse call system to obtain assistance during a seizure

STANDARD 4:

Evaluation - The nurse evaluates the patient's progress toward attaining expected outcomes and revises the plan of care accordingly.

Bibliography:


Related Forms:

- Standard of Nursing Care: Acute Care Adult Inpatient
- Standard of Nursing Care: Adult Inpatient Seizure Precautions & Monitoring (51soc) (Archived: Refer to CPG)
Supersedes:
None

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