

RN Protocol: Seizure

I. POLICY

- A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients experiencing seizure activity.
- B. Circumstances under which the RN may perform:
 - 1. Setting: Outpatient clinic and triage and treatment area.
 - 2. Supervision: None required.

II. PROTOCOL

- A. Definition: This protocol covers the assessment and treatment of patients who present with seizure activity. Seizure is defined as a temporary disturbance of brain function caused by abnormal electrical activity in the brain. Seizure activity is characterized by an increase in motor activity, a decrease in the state of consciousness, and an increase in autonomic activity (smooth muscle and glandular activity). Status epilepticus is defined as: (1) continuous, generalized, tonic-clonic seizure activity lasting more than 5 minutes; or (2) two or more discrete seizures without regaining full consciousness.
- B. Subjective:
 - 1. Statement from witness.
 - 2. History of missed seizure medication.
 - 3. History of head trauma.
 - 4. History of ETOH abuse.
 - 5. History of diabetes mellitus
 - 6. Current medications (including last dose taken) if patient is receiving anti-epileptic drugs (AED) or diabetic medication.
 - 7. Medication allergies.
- C. Objective:
 - 1. Assess ABC
 - 2. Vital signs.
 - 3. Assess for level of consciousness using Glasgow Coma Scale
 - 4. Check pupil size, shape and reactivity to light.
 - 5. Observe, describe, and document the following:
 - a. Cyanosis.
 - b. Apnea.
 - c. Abnormal eye movements
 - d. Automatism (e.g., lip smacking, swallowing, chewing, etc.).
 - e. Profuse salivation
 - f. Tonic-clonic movements.
 - g. Injury to mouth or limbs.
 - h. Urinary/stool incontinence.

6. Obtain a fingerstick blood glucose reading in the first 5 minutes.

D. Assessment:

- Risk for injury related to/evidenced by:
- Risk for aspiration related to/evidenced by:
- Alteration in tissue perfusion, cerebral, related to/evidenced by:

E. Plan:

ACUTE SEIZURE ACTIVITY (Seizure activity lasting less than 5 minutes)

1. Assess ABC (airway, breathing, and circulation). Use oral or nasopharyngeal airway if indicated.
2. Loosen clothing around neck.
3. Place patient in left lateral decubitus position to prevent aspiration. Suction any vomitus or excessive saliva from mouth.
4. Place on pulse oximeter and administer supplemental oxygen at 2-6L/minute via nasal cannula to maintain oxygen saturation above 92%.
5. Move potentially dangerous items away from the patient. Avoid restraining patient or forcing anything through clenched teeth.
6. Record the following:
 - a. Duration of seizure activity;
 - b. Type of seizure;
 - c. Whether the patient lost consciousness and how long he remained unconscious;
 - d. All behaviors observed during the seizure; and
 - e. Level of consciousness after the seizure.
6. Remain with the patient until vital signs are stable and seizure activity ends.
7. Draw venous sample for blood glucose, AED drug level (with clear clinical indications), CBC, and chem. panel.
8. Notify the physician.
9. If signs of injury are present, call Medical Officer of the Day for further direction.

STATUS EPILEPTICUS (Continuous seizure activity lasting more than 5 minutes or two or more discrete seizures without regaining full consciousness)

1. Assess ABC (airway, breathing, and circulation). Use oral or nasopharyngeal airway if indicated.
2. Loosen clothing around neck.
3. Place patient in left lateral decubitus position to prevent aspiration. Suction any vomitus or excessive saliva from mouth.
4. Place on pulse oximeter and administer supplemental oxygen at 2-6L/minute via nasal cannula to maintain oxygen saturation above 92%.
5. Move potentially dangerous items away from the patient. Avoid restraining patient or forcing anything through clenched teeth.
6. Record the following:

- a. Duration of seizure activity;
 - b. Type of seizure;
 - c. Whether the patient lost consciousness and how long he remained unconscious;
 - d. All behaviors observed during the seizure; and
 - e. Level of consciousness after the seizure.
7. Remain with the patient until vital signs are stable and seizure activity ends.
 8. Insert two intravenous lines and infuse Sodium Chloride Intravenous Solution (0.9%) at TKO rate.
 9. Draw venous sample for blood glucose, AED drug level (with clear clinical indications), CBC, and chem. panel.
 10. Notify physician **STAT**.
 11. Administer Lorazepam 4mg IV push over 2 minutes (give slowly not greater than 2mg per min) – wait 1 minute for response, then repeat if seizure continues. If unable to obtain IV access, administer Lorazepam 4mg IM.
 12. If patient is hypoglycemic or blood glucose level is not available, administer 50 ml of 50% Dextrose IV push over 2 minutes and Thiamine 100 mg IV.
 13. Monitor respiration and pulse every five minutes until stable, then every 15 minutes.
 14. Prepare to transfer patient to outside facility or admit to a facility capable of providing a higher level of care as indicated.
 15. Fax a copy of the relevant progress notes, physician orders, and emergency care flow sheet to receiving facility.
- F. Patient Education:
1. Assess patient's potential for understanding the health information to be provided.
 2. Provide patient education consistent with the assessment of the condition.
 3. Document the education provided and the patient's level of understanding on the emergency care flow sheet.
 4. Refer patient to other resources as needed. Document all referrals on the emergency care flow sheet.
 5. Advise patient to utilize the urgent/emergent process to access medical care if symptoms recur.

G. Documentation:

All information related to the patient's complaint shall be documented on the emergency care flow sheet. The flow sheet shall be filed in the patient's unit health record.

III. REQUIREMENTS FOR RN

- A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and management of seizures and achieve a minimum score of 80% on the written posttest examination.
- B. Experience: None.
- C. Certification: None

D. Initial Evaluation: Initial competence will be validated onsite through simulated exercises, mock scenarios, and return demonstration. The Registered Nurse must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include, but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

E. Ongoing Evaluation: Ongoing competence will be validated annually using case study analysis, written examination, and return demonstrations where appropriate.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all Registered Nurses authorized to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE: _____

REVISION DATE: _____

THE STANDARDIZED PROCEDURE WAS APPROVED BY:

Chief Nurse Executive/Director of Nursing

DATE: _____

Chief Medical Executive

DATE: _____