Southern Health
NHS Foundation Trust

SH CP 03

Management of Seizures:

What to do when an inpatient has a seizure.

Version: 2

Summary:	This policy provides the protocol for Southern Health NHS Foundation Trust inpatient clinical staff to safely manage an inpatient when they have a seizure.	
Keywords (minimum of 5): *(To assist policy search engine)*	Seizure, seizures, inpatient	
Target Audience:	Heads of Professions, Medical Staff, In-patient clinical staff.	
Next Review Date:	5 Years –March 2022	
Approved by:	Medicines Management Committee	**Date of meeting:** 31st May 2017
Date issued:	March 2017	
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Version Control

Change Record

Date	Author	Version	Page	Reason for Change
Jan 12	Dr C Underwood	1	All	Initial policy drafted
Mar 17	Jennifer Dolman	2	4	Update new policies, spelling and font
Mar 17	Jennifer Dolman	2	5	Update version number added
Mar 17	Jennifer Dolman	2	7	Section 11 reference added
Mar 17	Jennifer Dolman	2	8	Hypoglycaemia added to form

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Management of seizures: what to do when an inpatient has a seizure

1 Purpose

1.1 This policy provides the protocol for Southern Health NHS Foundation Trust inpatient clinical staff to safely manage an inpatient when they have a seizure.

1.2 This policy applies to all clinical staff working with inpatients in Southern Health NHS Foundation Trust.

2 Related Policies

2.1 This policy should be read in conjunction with the following documents;

- Southern Health NHS Foundation Trust Guidelines for the training in, and the administration of Midazolam Hydrochloride (Buccolam®) 10mg/2ml Oromucosal solution for the Management of Tonic - Clonic Status Epilepticus in Adults with a Learning Disability. (SH CP 04) Southern Health NHS Foundation Trust Medical Emergencies and Resuscitation Policy, version 2 (SH CP 30):

- Epilepsy in People with a Learning Disability Map (Version 2 September 2015) Found at link https://www.southernhealth.nhs.uk/knowledge/clinical-services/ld/caps-and-divisional-leads/epilepsyepilepsy/

3 Background

3.1 Epilepsy is a common condition, with an incidence of 80 per 100,000 persons per year and rates vary between 50 – 120 per 100,000 per year[1]. The point prevalence is ~ 4-10 cases per 1,000 persons, 10-50% of patients with epilepsy have psychiatric symptoms[2]. Withdrawal from alcohol and other substances, head injury and other physical health problems can be complicated by seizures

3.2 Tonic-clonic status has a mortality of 5-10%, with increased risks of morbidity the longer the duration of the status episode[1]. Early treatment of tonic-clonic seizures in the premonitory stage of status epilepticus reduces morbidity and mortality.

4 Principles

4.1 All patients with a history of epilepsy should have a clear description of their seizures included in their clinical notes/epilepsy profile and a buccal midazolam or rectal (pr) diazepam care plan where appropriate.

4.2 If a patient is admitted with a history of epilepsy and the inpatient staff require advice/support about recognising seizures and giving rescue medication, for example Buccal midazolam or pr diazepam the local Integrated Community Learning Disability Team can be contacted. The Epilepsy lead may be contacted by the Community Learning Disability Team if the presentation is complex or requires further information or advice.

4.3 These guidelines pertain to tonic-clonic (convulsive) seizures, previously called grand mal, as the risk of morbidity and mortality is particularly important to require prompt action by inpatient staff. However, this policy also describes the other types of seizures and the action to be taken to ensure the patient's epilepsy is reviewed as necessary by medical staff.

5 Recommendations

5.1 Nurses need to be competent to give rectal Diazepam and/or buccal Midazolam (refer to Southern Health NHS Foundation Trust Buccal Midazolam Training and Administration Guidelines SH CP 206).

5.2 Nurses need to be competent in recognising a generalised tonic-clonic seizure and understanding there are other seizures that a nurse may need to alert a doctor to.

6 Recognising a tonic-clonic (convulsive) seizure

- During a tonic-clonic seizure the person goes stiff, usually falls to the ground and shakes or makes jerking movements (convulses).
- Their breathing can be affected and they may go pale or blue, particularly around their mouth.
- They may bite their tongue.
- They may wet themselves.
- Some people have just clonic (convulsive) seizures. Usually, once the jerking has stopped, the person recovers and their breathing goes back to normal.

7 What to do when an inpatient has a tonic-clonic seizures

Refer to the flowchart.

8 What to do when a tonic-clonic seizure stops

- Roll them on to their side into the recovery position.
- Wipe away any spit and if their breathing is difficult check their mouth to see that nothing is blocking their airway, like food.
- Try to minimise any embarrassment. If they have wet themselves, deal with this as privately as possible.
- Stay with them, giving reassurance, until they have fully recovered and/or the paramedic arrives.

9 Other types of seizure and what to do

Epileptic seizures can be divided into two main types: partial or focal seizures and generalised seizures.

9.1 **Partial or focal seizures**: A partial seizure starts in, and affects, part of one side of the brain. What happens during the seizure depends on where in the brain the seizure happens and what this part of the brain normally does.

Type of seizure	*What to do during the seizure*
Simple partial seizures The person is conscious (awake) and aware of what is happening to them. A Simple Partial Seizure could be twitching of one limb or part of a limb, an unusual smell or taste, a strange feeling such as a 'rising' sensation in the stomach or 'pins and needles' in a part of the body, or a sudden intense feeling of fear or joy.	*Although the person is aware and aware, simple partial seizures can feel unsettling so giving gentle reassurance may be helpful.*
Complex partial seizures A complex partial seizure (CPS) affects a bigger part of the brain than a simple partial seizure. In a CPS the person's consciousness is affected and they may be confused. You might notice them wandering around or behaving strangely and they may not know what they are doing. They may pick objects up for no reason, fiddle with their clothes or make chewing movements with their mouth. Afterwards, they may need to sleep or they might be confused for some time. CPS may last from a few seconds to a few minutes	*• Do not restrain the person as this may upset or confuse them.* *• Gently guide them away from any danger.* *• Speak quietly and calmly so that they are not startled. They may be confused, so if you speak loudly or act forcefully this may confuse them more. They may mistake your help for being hostile, and be upset or respond in an aggressive way.* *<u>After the seizure stops:</u>* *• They may feel tired and need to sleep.* *• It may help if you remind them where they are because they may be confused and not fully aware of their surroundings.* *• Stay with them until they have recovered and can safely return to what they were doing before the seizure.*
Secondarily generalised seizures For some people simple partial seizures and CPS develop into a generalised seizure (see below). When this happens they become unconscious and will usually have a tonic clonic seizure. This is called a secondarily generalised seizure because it starts as a partial seizure and then becomes a generalised seizure. Some people call their partial seizure an 'aura' and a generalised seizure may follow.	*If the person is aware of a warning, they may need help to make themselves safe before the generalised seizure starts*. *If the person develops a generalised seizure manage according to the chart below.*

9.2 **Generalised seizures:** Generalised seizures affect both sides of the brain. The person usually becomes unconscious, and afterwards will not remember what happened during the seizure.

Type of seizure	*What to do during the seizure*
Absences (previously called petit mal) During an absence the person becomes unconscious for a short time, usually a few seconds. They may look blank and not respond to what is happening around them. For example, if they are walking they may continue to walk, but will not be aware of what they are doing	*Stay with the person and, if necessary, gently guide them away from any danger.*
Tonic and atonic seizures In a **tonic** seizure the person's muscles suddenly become stiff. If they are standing they often fall backwards and may injure the back of their head. In an **atonic** seizure (also called a 'drop attack') the person's muscles suddenly relax, and they become floppy. If they are standing they often fall forwards and may injure their face or head. Both tend to be very brief and happen without warning so you cannot help during the seizure itself. People usually recover quickly.	*As the person recovers they may need reassurance. If they have been injured, they may need medical help.*
Myoclonic seizures Myoclonic seizures involve jerking of a limb or part of a limb, and often happen shortly after waking up from sleep. They are brief and can happen in clusters with many happening close together in time. As they are so brief, there is nothing that needs to be done to help the person other than making sure they haven't hurt themselves.	*Usually self-limiting*

10 References

1. Shorvon, S. (2005). *Handbook of Epilepsy Treatment.* (2nd edition). Oxford: Blackwell Publishing Limited.

2. Semple, D et al. (2005). *Oxford Handbook of Psychiatry,* (1st edition). Oxford University Press.

3. Clinical Guideline CG137: Epilepsies: diagnosis and management. National Institute for Health and Care Excellence 2012 (updated 2016). Accessed via www.nice.org.uk

11 Acknowledgements

This policy includes information from, The national society for epilepsy (2010), *'What to do when someone has a seizure: first aid'.*
http://www.epilepsysociety.org.uk/AboutEpilepsy/Firstaid/Recordinginformationaboutseizures

Appendix 1 **WHAT NEEDS RECORDING?**

SEIZURE DESCRIPTION SHEET

NAME:		**DoB :**	
DATE OF SEIZURE:	**TIME OF START OF SEIZURE:**	**WHERE DID THE PATIENT HAVE THE SEIZURE?**	**SEIZURE OBSERVED AND RECORDED BY:**
LENGTH OF ACTUAL SEIZURE:		**APPROX RECOVERY TIME AFTERWARDS:**	

Please describe in your own words, what the person looked like/did prior, during and after the seizure

Was there anything which may have precipitated the seizure, e.g. Menstrual cycle, flashing lights, constipation, hypoglycaemia or infections

Please tick below to indicate what was happening to the person (or is thought to have happened) before, during and after the seizure.

Before

	Y	N		Y	N		Y	N
Unusual sensation – e.g. taste / smell			Lethargy / tired			Change in skin colour (if yes what colour?)		
'Twitching'			Very excited/ happy			Anxious		
Change in appetite			Racing heart/pulse			Undressing		
Change in sleep pattern			Scream / cry out			Other -		

During

The person became rigid			Eyes closed			Do they have involuntary jerky movements? If so		
The person became floppy			Eyes open					
Change in breathing pattern			Glazed / fixed stare			Face		
Cold and sweaty			Responds normally if talked to			Whole body		
Colour of skin blue			Doesn't respond if talked to			Left Arm		
Colour of skin red			Unusual response if talked to			Right Arm		
Mouth open			Crying/weeping			Left Leg		
Mouth closed			Repetitive actions/ movements			Right Leg		
Unusual sounds			Other -			Other		
Turns head to one side, if yes which side?			Incontinence – if so:,					
			Urine					
			Faeces					

After

Confusion			Tearful			Hyperactive		
Aggression			Change in appetite			Twitching		
Drowsy			Thirsty			Colour of skin -		
Headache			Other -					
Have you requested a review of their epilepsy? If not document reasons.								

Appendix 2 BUCCAL MIDAZOLAM OR PR DIAZEPAM TREATMENT PLAN

The Treatment Plan must clearly specify the exact intervals when medication is to be administered in an epileptic seizure.

The individual Treatment Plan is prescribed by a doctor in collaboration with the nurse and patient.

Patient's Name: **Date of Birth:** **Address:** **Date operational from:** **Review Date:** **Completed by:**
Seizure classification and description of seizures which may require buccal midazolam or pr diazepam:
After how long of seizure activity should buccal midazolam or pr diazepam be administered?
What is the first dose of buccal midazolam or pr diazepam that should be administered?
If there are difficulties in the administration of buccal midazolam or pr diazepam what actions should be taken?

What is the patient's usual reaction to buccal midazolam or pr diazepam?
Can a second dose of buccal midazolam or pr diazepam be given? **After how long can a second dose of buccal midazolam or pr diazepam be given?** **How much buccal midazolam or pr diazepam can be given as a second dose?**
What is the maximum dose that can be given in 24 hours?
When should 999 be dialled for emergency help?
When should the patients GP be consulted?
Who should witness the administration of buccal midazolam or pr diazepam?
Who needs to be informed?
Under what circumstances should buccal midazolam or pr diazepam NOT be given?

ALL OCCASSIONS WHEN BUCCAL MIDAZOLAM OR PR DIAZEPAM IS ADMINISTERED MUST BE RECORDED

When calling 999 to summon an ambulance say:

'This is _____ (include your name, address and phone number). We have a patient who has had an epileptic seizure.
Buccal midazolam or pr diazepam has/has not been given. We need a paramedic team urgently.

The patient's name is _____and date of birth is_____'

- Inform ambulance control of the exact location and best entrance to use and state that the crew will be met and taken to the patient (if possible).

- Speak clearly and slowly and be ready to repeat information if asked.

- Send a member of staff to wait at the entrance to direct the ambulance crew as necessary.

EVALUATION SHEET AND RECORD OF USE OF BUCCAL MIDAZOLAM OR PR DIAZEPAM

NAME OF PATIENT…….. **D.O.B**……

DATE					
RECORDED/ADMINISTERED BY					
TYPE OF SEIZURE					
LENGTH AND/OR NUMBER OF SEIZURES					
INITIAL DOSAGE					
OUTCOME					
SECOND DOSAGE (IF ANY)					
OUTCOME					
OBSERVATIONS					
PARENT/GUARDIAN INFORMED					
PRESCRIBING DOCTOR INFORMED					
OTHER INFORMATION					
WITNESS					