

## RN Protocol: Seizure

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### 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 the function:
  - 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 (airway, breathing, and circulation)
  - 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).
    - 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: (specify on associated encounter form)
- Risk for aspiration related to/evidenced by: (specify on associated encounter form)
- Alteration in tissue perfusion, cerebral, related to/evidenced by: (specify on associated encounter form)

E. Plan:

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

1. Assess ABC. 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. Draw venous sample for blood glucose, AED drug level (with clear clinical indications), CBC, and chem. panel.
9. Notify the Primary Care Provider (PCP).
10. If signs of injury are present, call the Medical Provider On-Call when after-hours 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. 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/she remained unconscious;
    - d. All behaviors observed during the seizure; and
    - e. Level of consciousness after the seizure.
  7. Notify the PCP **STAT**.
  8. Insert intravenous lines (start with one, place additional line when time permits) and infuse Sodium Chloride Intravenous Solution (0.9%) at TKO rate. Administer Lorazepam 2mg IV push over 1 minute (give slowly not greater than 2mg per min)
    - a. Wait 1 minute for response, if seizure activity continues give an additional 2mg Lorazepam IV push slowly over 1 minute.
    - b. Wait 5-10 minutes, if seizure activity continues contact the PCP for additional orders (2 additional doses of Lorazepam 2mg IVP over 1 minute, 1 minute apart).
  9. 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.
  10. Draw venous sample for blood glucose, AED drug level (with clear clinical indications), CBC, and chem. panel.
  11. Monitor respiration and pulse every 5 minutes until stable, then every 15 minutes.
  12. Prepare to transfer patient to outside facility or admit to a facility capable of providing a higher level of care as indicated.
  13. Fax a copy of the relevant progress notes, PCP orders, and emergency care flow sheet to receiving facility.
  14. Remain with the patient until vital signs are stable and seizure activity ends.
- F. Patient Education:
1. Assess the 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 in the health record.
  4. Refer patient to other resources as needed. Document all referrals in the health record.
  5. Advise the patient to notify staff immediately in order to access medical care if symptoms recur.
  6. Advise the patient to resubmit a CDC 7362, Health Care Services Request Form if he/she has questions regarding medications, side effects, or treatment plans.
- G. Documentation:
- All information related to the patient's complaint shall be documented on the emergency care flow sheet, nursing protocol encounter form, or progress note and filed in the patient's health record.

**III. REQUIREMENTS FOR THE REGISTERED NURSE**

- A. Education/Training: The RN 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 RN 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 RN 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**

The Chief Nurse Executive shall ensure a current list of all RNs authorized to perform this procedure is on file within Nursing Services as required by Inmate Medical Services Policies and Procedures, Volume 5, Chapter 4.2, Nursing Competency Program Procedure.

**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: \_\_\_\_\_  
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REVISION DATE: \_\_\_\_\_  
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THE STANDARDIZED PROCEDURE WAS APPROVED BY:

\_\_\_\_\_  
Chief Nurse Executive

DATE: \_\_\_\_\_

\_\_\_\_\_  
Chief Medical Executive

DATE: \_\_\_\_\_