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**Management of Seizures**

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1. **Purpose and Application**

This policy has been developed to provide guidance and information about how manage seizures

**What are Seizures?**

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**Care plans**

**SUDEP**

The policy will apply to:

* **Permanent employees**
* **Temporary employees**
* **Agency workers**

It will be the responsibility of managers to take any necessary action if this policy is not adhered to, taking into account the relevant regulatory responsibility.

1. **Responsibilities**

**The nominated individual** is accountable for the implementation of this policy in its entirety. They are a key contact for the service.

**The registered manager and any trained nurses** are responsible for the implementation of this policy and to evidence training in recognition and treatment of seizures.

**Any care staff** that have had training and are able to recognise and support a person who is having a seizure.

1. **Legislation and Regulation**

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12**

The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

Providers must make sure that the premises and any equipment used is safe and where applicable, available in sufficient quantities.

Providers must prevent and control the spread of infection. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people's health, safety and welfare.

CQC understands that there may be inherent risks in carrying out care and treatment, and they will not consider it to be unsafe if providers can demonstrate that they have taken all reasonable steps to ensure the health and safety of people using their services and to manage risks that may arise during care and treatment.

CQC can prosecute for a breach of this regulation or a breach of part of the regulation if a failure to meet the regulation results in avoidable harm to a person using the service or if a person using the service is exposed to significant risk of harm. They do not have to serve a Warning Notice before prosecution.

Please also refer to:

<https://pathways.nice.org.uk/pathways/epilepsy>

<https://www.nice.org.uk/guidance/CG137>

1. **Management of Seizures**

**What are seizures?**

A seizure happens when the nerve cells in the brain stop working in harmony and the brain’s messages become mixed up. A seizure can affect part of the brain or the whole brain.

It is important that staff are trained in the use of “rescue medication” that may be prescribed and trained to recognize and deal with seizures.

**Common types of seizure**

The most common types of seizure are:

**Tonic-Clonic seizures** (previously known as grand-mal)

Theseare the most recognised type of seizure. During this type of seizure, the person will lose consciousness. Their body will go stiff, and their limbs will jerk. They will regain consciousness once their seizure is over, but they may be tired

and disorientated for many hours after. There is a risk of asphyxia and aspiration if

the airway is not kept clear during a seizure, as well as possible injury to limbs due to involuntary spasms during a seizure.

After a tonic-clonic seizure, muscles relax, and the body goes limp. Slowly, the person will regain consciousness but may well be groggy or confused. They will gradually return to normal but may not be able to remember anything for a while. It is usual to feel sleepy and have a headache and aching limbs. Recovery times can be different for different people. Some people will quickly want to get back to what they were doing, some people will need a short sleep, and others will need plenty of rest.

**Absence seizures** (previously known as petit-mal)

During this type of seizure, the person will very briefly lose consciousness and will appear to be daydreaming for a few seconds. A person who has this type of epilepsy may experience seizures many times a day. No specific first-aid treatment is required for this type of seizure. Because anybody can daydream at any time, absences can be very hard to spot. It is possible to have hundreds of absence seizures a day, preventing people from fully taking part in daily activities. They could also miss out on tiny pieces of information or events. This may be mistaken for lack of attention or concentration.

**Complex partial seizures**

This type of seizureis often difficult to spot. The person will not be fully aware of what

is happening. They may be doing things repeatedly, such as rubbing their hands or

swallowing. No specific first aid treatment is required. Do not try to restrain the person unless they are in immediate danger, they may not recognise you and become frightened.

**Myoclonic seizures**

During this type of seizure, the person’s muscles will jerk. It can affect any muscles inthe body but most commonly affects the muscles in the arms. Myoclonic seizures are most common in the morning. They may cause tiredness and lack of concentration.No specific first aid treatment is required, but the person may need reassurance ifdistressed.

**Atonic seizures**

In an atonic seizure, the person will lose all muscle tone and drop heavily to the floor. The seizure is very brief, and they are usually able to get up again straight away and are not confused afterwards.

Because the body usually falls forward in an atonic seizure, people are at risk of banging their head on furniture or other hard objects. If they have frequent atonic seizures, extra safety precautions, like protective headgear, make sense.

**Tonic seizures.**

In a tonic seizure, all the muscles tighten. The body stiffens and the person will fall over unless they are supported. Tonic seizures usually last less than 20 seconds and most often happen during sleep.

**Rescue Medicine**

The only time medicine may be urgently needed by a person is when their seizure fails to

stop after the usual time or they have a series of seizures. Staff must be aware of the individualised care plan and risk assessment for rescue medication for details of when to administer medication. An ambulance should be called if for any reason emergency medication cannot be administered or as dictated on the plan of care and risk assessment.

**After Care**

Continue to monitor the person to make sure they are recovering and breathing well.

Stay with them and offer reassurance. It is likely that they may feel sleepy, disorientated and be experiencing short-term memory loss. Do not give food or drink until the person is fully awake and alert. Refer to the individual’s care plan and risk assessment for details of how they usually respond after a seizure.

If at any time there is concern about the person, seek immediate medical advice.

Record details of the seizure, i.e., length of time and observations on the person’s seizure

chart.

Complete the MAR chart if any emergency treatment has been given and detail if the result was as expected. Contact the NOK at the earliest convenience. Record details of the seizure in the daily documentation and seizure chart, together with information about any rescue medication that may have been given.

**Care plans**

Care plansshould include but not be restricted to**:**

* Information about how the seizure presents itself, details about people’s rescue medicines. This should include what effect these should have and within what time frame when staff need to seek more help. For example, when to call for an ambulance.
* If people have been prescribed rescue medicines, make sure there are appropriate quantities in stock, check and reorder before the expiry date.
* NICE guidance states that you should call an ambulance if a seizure continues 5 minutes after administering emergency medicines, the person has a history of frequent episodes of serial seizures, the person has convulsive status epilepticus, this is the first episode requiring emergency treatment, there are concerns or difficulties monitoring the person's airway, breathing, circulation or other vital signs.
* It is also important to include in plans of care, areas identified that may cause injury if a seizure occurs such as having a shower or bath, housework such as cooking and ironing to name a few. This list is not exhaustive. Consent needs to be considered as medication may need to be given if the person in unconscious and awareness of the mental capacity and best interest decision process must be taken into consideration on an individual basis and documented. It is also important that if the person suffers from constipation that a risk assessment is in place.

**SUDEP**

Sometimes a person with epilepsy dies during or following a seizure for no obvious reason. This Sudden Unexpected Death in Epilepsy (SUDEP) is uncommon and in some cases may be preventable. SUDEP is defined as: the sudden, unexpected, witnessed or unwitnessed, non-traumatic, and non-drowning death in patients with epilepsy with or without evidence for a seizure. This means that SUDEP is when someone is believed to have died during or after a seizure where no other cause of death can be found.

**The risk factors around SUDEP**

As SUDEP is thought to happen during or following a seizure, uncontrolled or poorly controlled seizures are a risk. SUDEP is thought to be more likely in people with frequent seizures, particularly convulsive seizures, than in people with infrequent seizures. It is worth remembering that the risk of SUDEP varies from one person to another, but some of the risks around SUDEP can be reduced.

**Reducing risk**

Taking anti-epileptic drugs (AEDs) consistently (every day) and around the same time or times each day as prescribed and keeping a diary of when seizures happen. This will help to show if there is a pattern to the seizures and whether any situations trigger a seizure (like being tired or stressed.) SUDEP often happens when the person is asleep. If they have seizures during sleep, having a seizure alarm that alerts someone who can help if they have a seizure in bed may help in reducing the risk.

**5. Equality Impact Assessment**

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| **Equality Impact Assessment Checklist** | **Yes/No?** |  **Comments** |
| **1.** | Does the procedural document affect one group less or more favourably than another on the basis of: |  |  |
| * Race?
 | No |  |
| * Ethnic origins (including gypsies and travelers)?
 | No |  |
| * Nationality?
 | No |  |
| * Gender?
 | No |  |
| * Culture?
 | No |  |
| * Religion or belief?
 | No |  |
| * Sexual orientation, including lesbian, gay and bisexual people?
 | No |  |
| * Age?
 | No |  |
| **2.** | Is there any evidence that some groups are affected differently? | No |  |
| **3.** | If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? | N/A |  |
| **4.** | Is the impact of the procedural document likely to be negative? | No |  |
| **5.** | If so, can the impact be avoided? | N/A |  |
| **6.** | What alternatives are there to achieving the procedural document without the impact? | N/A |  |
| **7.** | Can we reduce the impact by taking different action? | N/A |  |

If you have identified a potential discriminatory impact of this procedural document or need advice, please document the action required to avoid/reduce this impact.