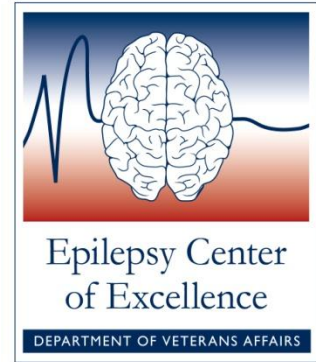


EPILEPSY MONITORING UNIT PROTOCOLS

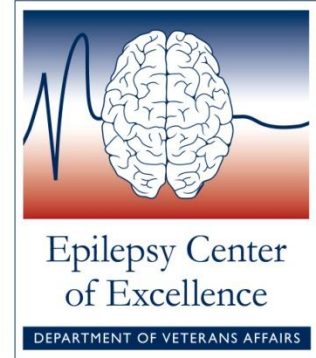
A. NURSING CARE PLAN: SAFETY

1. Potential for injury related to seizure activity, secondary to decrease/discontinuance of anti-epileptic drugs (AEDs).
2. Goal: Patient will not sustain any preventable injury during hospital stay.
3. Interventions:
 - a. All four bed rails padded and up at all times except for meal times. During meals, one bottom rail can be down to accommodate the overbed table or patient may be assisted to a chair. Ensure patient is in full view of camera.
 - b. Nurse light and seizure alarm device (*this may be a push button or paddle depending on facility*) within reach of patient.
 - c. Patient must never get out of bed without assistance. Consider increasing vigilance toward end of stay when seizure risk is higher.
 - d. If a sitter is assigned, he/she must sign a document that verifies reading a description of the patient's events.
 - e. Each nurse assigned to a seizure telemetry patient must read and sign a description of the patient's events.
4. Room set up may vary at each facility. At a minimum the room must have:
 - a. Wall suction set-up with Yankauer suction tip.
 - b. Oxygen flow meter with oxygen tubing and nasal cannula attached.
5. Saline lock in place, monitored and changed per hospital policy.



B. NURSING CARE PLAN: PATIENT EDUCATION

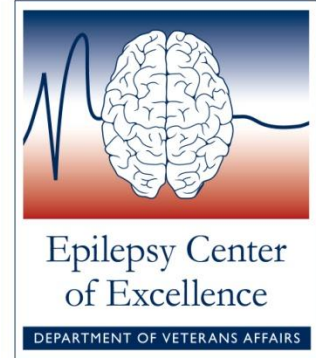
1. Knowledge deficit related to seizure telemetry protocols.
2. Goal: Patient will verbalize understanding of seizure telemetry protocols and will agree to comply with these protocols. Depending on the facility, the *patient may be asked to sign the Education Nursing Care Plan.*



3. Interventions:

- a. Ensure the patient knows how to use the event alarm. Explain to the patient that this device should never be pushed unless the patient is feeling different, having an aura, or feels like an event is coming on or has already started. If the patient will have family or friends staying in the room or frequently visiting, make sure they know how to push the event alarm device as well in case they witness an event and the patient is unable to press the button/paddle.
- b. Depending on the facility, some patients may be asked to press both the seizure alarm device and the nursing call light.
- c. Instruct the patient not to get out of bed without assistance. Explain the need to have someone with the patient if an event occurs.
- d. Inform the patient that the decrease or removal of AEDs may result in more frequent or different types of types of events.
- e. Inform the patient that he/she cannot shower or get any of the equipment wet. The patient may have a "sponge bath" with a damp cloth. Male patients will not be permitted to shave because of the placement of electrodes on the facial margins. The patient will not be able to take the equipment off. Once placed, the battery pack/amplifier must stay with the patient at all times. Explain the

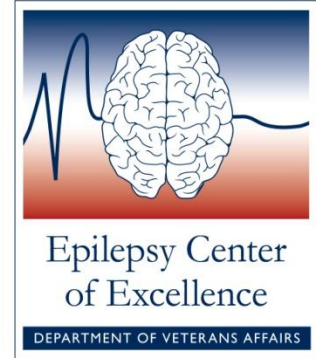
need to have button, snap or zip up tops to facilitate clothing changes. The patient will not be allowed to remove anything over the head once the electrodes are in place.



- f. Remind the patient that all medications will be provided by the facility and the patient should not take anything from his/her own supply.
- g. Instruct patient to keep the padded bed rails up at all times except at meal times or when assisted out of bed.
- h. Remind the patient that the camera and audio is on at all times. Also, there is a microphone in the room and sound is being recorded simultaneously with the digital image.
- i. Inform the patient that there is no smoking or chewing tobacco during monitoring. Nicotine patches are available. Inform the patient that there are no food or fluid restrictions unless ordered by provider. The patient may have alternative meals, snacks and drinks brought in by family or friends. Inform the patient that there is to be no gum chewing or chewing of hard or chewy candy that might be a choking hazard or confused with oral automatisms. Explain to the patient that he/she will not be allowed to have access to any sharp objects while being monitored i.e. knitting or sewing needles, razors, and pins.

The information above was explained to the patient and questions addressed. The patient verbalizes understanding and agrees to comply with the seizure telemetry protocol.

SEIZURE TELEMETRY STANDING ORDERS



Ictal Spect Patients:

INTRAVENOUS ACCESS

All ictal spect patients will have a 20 gauge saline lock **without a J loop** (increases time it takes for radioactive Isotope to reach patient's bloodstream) ordered and placed upon admission to the VA and maintained in accordance with hospital policy by the RN and Patient Support Team for the entire admission.

PREGNANCY TEST

All females with reproductive capacity need to have pregnancy tests prior to injection.

Surgical Grid Patients:

INTRAVENOUS ACCESS

Dependent on the facility, a PICC line may be placed in the GRID patient. If placed, the PICC line is maintained in accordance with hospital policy by the RN and Patient Support Team for the entire admission.

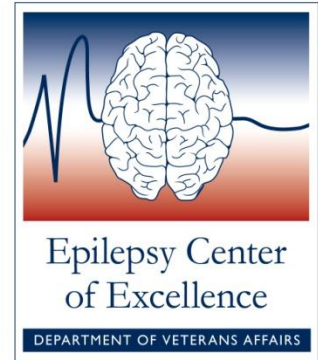
Grid Mapping

Orders for benzodiazepines are MD dependent. Some facilities may have standing orders for lorazepam at the bedside.

All Seizure Patients:

CONSTIPATION

Immobility can increase the risk of constipation by decreasing gastrointestinal motility. Patients in the Epilepsy Monitoring Unit are confined to their bed for most of the admission, and are at increased risk for constipation. The RN should assess the patient thoroughly and then determine the proper intervention based on the patient's input and laxative guidelines. Laxative medications will be available to the chronic or acutely constipated patient.



EXERCISE

Pedal exerciser or similar approved device to be used PRN for exercise.

BENZODIAZEPINES

Use of benzodiazepines is MD and facility dependent. Some facilities may have a standing order in place for lorazepam to be used as needed. Contact the Neurology Service and inform the EEG technologist if a benzodiazepine is used.

SLEEP DEPRIVATION

Sleep deprivation is frequently ordered to help induce events. The time frame for the sleep deprivation starts at the time the order is written unless otherwise specified. The time span for sleep deprivation is dependent on the MD and the facility. Generally, there are no food, fluid, or caffeine restrictions during this time unless so ordered.

DIPHENHYDRAMINE

Use of diphenhydramine for scalp itching is MD and facility dependent. Some facilities may have a standing order in place for diphenhydramine to be used as needed.