

# Status Epilepticus Bedside Worksheet

## Quick Reference for the New to Neuro or Neuro Care Unit Nurse

This educational check is provided as an example to guide care. It is not intended to replace any institutional standards or practices.

- ICU Bedside Admission Routine
- Assess, respiratory, hemodynamics.
- Prepare for possible Intubation for airway protection and mechanical ventilation if appropriate.
- Emergent EEG, continuous monitoring, (MRI compatible leads?)
- Established communication between provider, nurse and EEG technologist and reference protocol of communication (example below)
  - Review medication and specific seizure medications, Best Practice suggestion: Providers should review EEG & write order before any titration of continuous seizure medication.
  - EEG review responsibilities re unit standards.
- Critical care monitoring. vital sign assessment & goals, vascular access in place
- Review EMR order set for status (if one established)
- Consultations
- Review patient presentation-repetitive tonic clonic movements versus comatose and unresponsive. Convulsive versus Nonconvulsive.
  - Neuro assessment
  - Communicate with the pharmacy regarding drug preparation timing and delivery in this patient population
  - Initiate ongoing ICU Unit Standards of General Care
    - Family communication/education plan
    - Skin assessment (including scalp)
    - Scalp electrode placement
    - Eye care
    - Oral care
    - Bowel and Bladder care
    - Mobility assessment & plan
    - Nutrition assessment & plan
  - Finger stick glucose and other lab values-Urine drug screen
  - Imaging Studies
  - MRI (can patient travel?)
  - CT (portable or travel?)

# Example of Critical Communication Response for EEG Changes/status Concerns

This process will vary depending on the institution and resources available.

Some facilities may have continuous monitoring in an ICU setting and some in an Epilepsy Monitoring Unit. An EEG technician is not always available to monitor EEG depending on the facility.

## General Considerations:

**Provider/ designee-** The provider designated to read the EEG interpretation is responsible for reporting changes to the nurse and for contacting other team members as needed.

**Changes in EEG patterns** are identified by the technologist or nurse-when specific abnormal patterns and findings are seen-

***Nursing should not be interpreting the EEG but should be aware of the difference between normal and abnormal and report change***

### Possible examples

- Status-convulsive versus non convulsive
- Frequent epileptiform discharges for patients on no AEDs
- Patient having two or more seizures during the recording with no AEDS
- Several seizures with the patient on seizure medications
- Change in frequency of amplitude in one hemisphere-possible suppression or slowing
- Any change from pattern seen when last checked.

## Process:

1. The technologist or nurse gives a verbal description of EEG activity to the provider, along with any clinical correlation seen by nursing and EEG
2. It is the responsibility at that time for the provider to read and interpret the data and report his/her findings immediately to the team, RN, EEG technologist etc.
3. The interpreting provider (if not responsible for care decisions) will also contact the patient care provider.
4. The response time is critical-It should be expected that the call from the provider will be immediate-with a goal of 10 minutes for provider response. If the responsible provider has not responded within 10 minutes-there should be a designated backup provider available to contact
5. The provider can specify a new critical value for the technologist or nurse if the patient continues to have reportable events.
6. There should be established expectations regarding documentation of events as they occur and when future communications and contact occurs-depending on the designated critical value.