NAME _____

Seizures

Date	Problem	Goal/Outcome	Interventions	Date	Evaluation	NOTES
	Related To: □ DD □ TBI □ Infection/Fever □ other (list) AEB: □ grand-mal □ focal □ loss of muscle coordination □ cognitive limitations □ altered Consciousness □ Starring off □ Repetitive behavior □ Drowsiness □ Nausea/Vomiting □ Headache	1. No seizure activity for _____ (state time period) 2. No injury noted during convulsive episode 3. No med side effects/toxicity	**NURSING** 1. Obtain/Review seizure management plan from prescriber • Actions/ measures to take when seizure activity occurs 2. Complete assessment to include identifying any pre seizure activity/ contributing factors • Aura • Unusual behavior • Environmental • other 3. Develop safety plan to prevent injuries during seizure activity 4. Review seizure meds and appropriate lab for therapeutic range of meds 5. other (list)		***(Address all items listed in "goal/outcome" column. If goal not met, revise plan)***	

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			DELEGATE 1. Assist with meds as directed 2. Take VS as directed and after seizure activity 3. Do not leave person during/after seizure • reorient persons following seizure activity 4. Assist persons to floor if out of bed – DO NOT RESTRAIN 5. Keep safe from injury; support head and turn to side 6. other (list)			
RN SIGNATURE:				**DATE:**		