SEIZURE MANAGEMENT SUPPORT PLAN

Identified need for management	Goals	Interventions
High risk of seizures secondary to: **Medical Condition** ☐ Epilepsy **Other Health Conditions** ☐ Febrile (high temperature) ☐ Stroke ☐ Low Blood Sugar ☐ Extremely High Blood Pressure ☐ Brain Infection (Meningitis) ☐ Vascular Brain Abnormality ☐ Brain Tumour ☐ Birth Defect ☐ Traumatic Brain Injury **Other** ☐ Allergic Reaction to Medicines ☐ Substance Use ☐ Alcohol withdrawal ☐ Recreational Drugs State: _____ **Evidenced by** ☐ Medical History ☐ Seizure History ☐ Medical Notes ☐ Clinical Assessment ☐ Health Care Directive Date: _____ Family History of Seizures ☐ Yes ☐ No If yes, state type: _____	☐ Prevent/control seizure activity ☐ Prevent injuries/complications and promote safety ☐ Maintain airway/respiratory function ☐ Promote self-esteem, and decrease feelings of anxiety, fear, and helplessness ☐ Provide information and education about epilepsy, its prognosis, treatment requirements, medications, and therapeutic regimes to control/eliminate seizure activity **Seizure Types** ☐ Tonic-clonic (Grand Mal Seizure) ☐ Absent (Petit Mal Seizure) ☐ Focal (Simple Partial Seizure) ☐ Atonic (Generalised Seizure) ☐ Myoclonic (Generalised or Genetic Seizure)	**Identify triggers/stimuli that precipitate seizure activity:** ☐ Missed or changed medication ☐ Poor sleep quality/not enough sleep ☐ Dehydration/not enough fluids ☐ Stress (physical or emotional) ☐ Constipation ☐ Flashing lights (photo sensitivity) ☐ Flickering TV screens ☐ Environmental factors (change in home environment, temperature, noise) ☐ Other: _____ **Identify warning signs, and usual activity or patterns:** ☐ Behaviour changes – irritable, pacing ☐ Presence of aura ☐ Poor appetite ☐ Usually mobile, now sitting still ☐ Drooling ☐ Automatisms (e.g., lip smacking, chewing, picking at clothes) ☐ Other (state): _____ **General Interventions** When to call “000” for an ambulance for hospital transfer: ☐ If support worker has any doubts ☐ If a convulsive seizure lasts more than _ _ minutes ☐ If a non-convulsive seizure lasts more than _ _ minutes ☐ Cluster of seizures (Acute Repetitive Seizures) – Status Epilepticus ☐ Seizure occurs in water ☐ Seizure occurs when person is eating or drinking at the time

		☐ If the person experiences a new seizure type ☐ If this is a first seizure event for the person ☐ If person does not return to their usual self ☐ If person is injured ☐ Difficulty in breathing is observed

RISK / RESPONSE (SPECIFIC INTERVENTIONS)

SEIZURE DESCRIPTION	DURATION	FREQUENCY	SEIZURE FIRST AID INTERVENTIONS
TONIC-CLONIC SEIZURES (Grand Mal Seizures)			
Before seizure: **During seizure:** **After the seizure:** **Medications** Seizure medication: ☐ Yes ☐ No If yes, state medication/s: _____ Other medications: ☐ Yes ☐ No If yes, state medication/s: _____			1. **Time** the seizure 2. Support the head 3. Put something soft under the head 4. Loosen tight clothing 5. **Gently** roll onto side 6. **Stay** with the person until fully recovered 7. **Reassure & Reorientate** 8. **Respond** to any injuries 9. **Record** in seizure log (what happened before, during and after) and in person's records 10. **DO NOT** restrain 11. **DO NOT** put anything in the mouth 12. **DO NOT** give food or drink until fully recovered Does the person have specific requirements for how they wish to be cared for during a seizure episode? ☐ Yes ☐ No If yes, state requirements: _____
ABSENCE SEIZURES (Petit Mal Seizures)			
Before seizure: **During seizure:** **After the seizure:**			1. **Recognize** that the seizure has occurred 2. **Reassure & re-orientate** to environment 3. **Repeat** any information missed 4. **Stay** with the person until fully recovered 5. Record seizure episode details in seizure log and person's records Does the person have specific requirements for how they wish to be cared for during a seizure episode? ☐ Yes ☐ No

Medications Seizure medication: ☐ Yes ☐ No If yes, state medication/s: _____ Other medications: ☐ Yes ☐ No If yes, state medication/s: _____			If yes, state requirements: _____
FOCAL SEIZURES (Simple Partial Seizures)			
Before seizure: **During seizure:** **After the seizure:** **Medications:** Seizure medication: ☐ Yes ☐ No If yes, state medication/s: _____ Other medications: ☐ Yes ☐ No If yes, state medication/s: _____			1. **Time** the seizure 2. **Protect** from injury • remove objects the person may bump into • redirect away from dangers • encourage to sit down 3. **Stay** until the person has fully recovered 4. **Reassure & reorientate** 5. **Respond** to any injuries 6. **Record** in seizure details in seizure log and person's records 7. **DO NOT** restrain 8. **DO NOT** put anything in mouth 9. **DO NOT** give anything eat or drink until fully recovered Does the person have specific requirements for how they wish to be cared for during a seizure episode? ☐ Yes ☐ No If yes, state requirements: _____
ATONIC SEIZURES (Generalised Seizures)			
Before seizure: **During seizure:**			1. **Time** the seizure 2. **Protect from injury** • Remove objects • Support head • Roll onto side 3. **Stay** with the person until fully recovered 4. **Reassure & Reorientate** after the seizure is over**,** using simple and clear language

After the seizure: **Medications:** Seizure medication: ☐ Yes ☐ No If yes, state medication/s: _____ Other medications: ☐ Yes ☐ No If yes, state medication/s: _____			5. **Respond** to any injuries that may have been sustained during the seizure 6. **Record** seizure details in seizure log and person's records Does the person have specific requirements for how they wish to be cared for during a seizure episode? ☐ Yes ☐ No If yes, state requirements: _____
MYOCLONIC SEIZURES (Generalized or Genetic Seizures)			
Before seizure: **During seizure:** **After the seizure:** **Medications:** Seizure medication: ☐ Yes ☐ No If yes, state medication/s: _____ Other medications: ☐ Yes ☐ No If yes, state medication/s: _____			1. **Time** the seizure 2. **Protect from injury** 3. **Stay** with the person until fully recovered 4. **Reassure & Reorientate** after the seizure is over**,** using simple and clear language 5. **Respond** to any injuries that may have been sustained during the seizure 6. **Record** seizure details in seizure log and person's records Does the person have specific requirements for how they wish to be cared for during a seizure episode? ☐ Yes ☐ No If yes, state requirements: _____

Prepared by:		
Position Title:		
Signature:		Date:
Reviewed and Approved by:		
General Practitioner Name:		
General Practitioner Signature:		Date:
Health Professional Name:		
Health Professional Signature:		Date:

Agreement

By signing this Support Plan, I agree that I have been involved in the development of my plan. I agree and consent to the care and interventions of this Seizure Management Support Plan.

Participant/Representative Name:		
Participant/Representative Signature:		Date:
Company Representative Name:		
Company Representative Signature:		Date:

Communication / Copy of Support Plan	
Copy of Support Plan given to:	☐ Participant ☐ Health Professional ☐ Health Practitioner ☐ Other:

Progress Chart

Date	Change to Identified Need / New Problem	Intervention	Name / Signature / Delegation

Evaluation Chart

Date	Evaluation	Name / Signature / Delegation

High Risk of Seizure Management Directive
Neurologist / Medical Practitioner

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

High Risk of Seizure Management Directive
Health Professional / Epilepsy Nurse

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Document Control

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