# Policy: S42
## Seizure and Epilepsy Policy

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<th>Version:</th>
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<td>Clinical Governance Group</td>
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| Key Policy Stakeholders | Medical Director  
Director of Primary Care & General Practitioner HSS  
Director of Nursing & Patient Experience  
Acting chief pharmacist  
Head of Mental Health Law and Clinical Records  
Infection Control Specialist nurse  
Head of Nursing Local Services  
Head of Nursing Community Services  
Community and Inpatient Occupational Therapy Leads  
Head of Governance |
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| Review date: | August 2021 |
| Target audience: | All staff trust wide |
| Disclosure Status: | B Can be disclosed to service users and the public |

## EIA / Sustainability

- EIA Seizures policy.doc

## Other Related Procedure or Documents include:
- M2 medicines policy
- M9 Mental Capacity Act Policy
- M15p - National Early Warning Score Policy (previously MEWS)
- F8: Prevention of inpatient falls and care and treatment of a patient following a fall or head injury
- Infection control
Equality & Diversity Statement

The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all relevant policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed.

Sustainable Development Statement

The Trust aims to ensure its policies consider and minimise the sustainable development impacts of its activities. All relevant policies are therefore required to undergo a Sustainable Development Impact Assessment to ensure that the financial, environmental and social implications have been considered. Policies will only be approved once this process has been completed.
### S41 Seizure and Epilepsy Policy

Version Control Sheet

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1. Flowchart One

Inpatient Actions New Seizure

All Seizures – First or Known Epilepsy or Suspected Pseudo-seizures (unknown)

Step 1 - Emergency

FIRST AID + CALL FOR HELP
Blood Glucose Levels

Notify Duty Doctor

Basic Life Support if ABC is Abnormal

According to location of Inpatient facilities

- Call Ambulance (999) or follow local protocol for contacting CRASH teams

Step 2 – After care

- Referral to Specialist within 14 days of first seizure for, full physical health examination, clinical history, diagnosis & investigations
- Stop Driving until Specialist Assessment
- Avoid potentially dangerous work or leisure activities – swimming/bath unsupervised
- Advise and Essential information about Epilepsy, how to recognise, manage and give first aid.
- Awareness of triggers
- Nursing staff to request OT carry out a bathing assessment

• Type 1: Loss of Awareness, Shaking or Jerking, Fall to floor, Go still, tongue bites, wet themselves
• Type 2: Awareness preserved, Confused, Unusual behaviours – plucking at clothes, smacking of lips, swallowing or walking around.

• Be calm, stay with them until fully recovered.
• Look around for any dangers
• Cushion head, don’t hold them down, and don’t put anything in mouth.
• Note time – Start & End
• Once seizure is finished, put in recovery position after checking Airway-Breathing-Circulation (ABC) is normal.

• First Seizure
• Seizure continues more than 5 minutes
• Injured during seizure
• You believe they need urgent medical attention

• Primary Epilepsy
• Fever
• Head injury, Brain infection or Stroke
• Substance misuse or medication related
• Electrolyte imbalance/Low BM
• Eclampsia
1. Flowchart two

Inpatient Actions People with diagnosed epilepsy

- Type 1: Loss of Awareness, Shaking or Jerking, Fall to floor, Go still, tongue bites, wet themselves
- Type 2: Awareness preserved, Confused, Unusual behaviours – plucking at clothes, smacking of lips, swallowing or walking around.

- Be calm, stay with them until fully recovered.
- Look around for any dangers
- Cushion head, don’t hold them down, and don’t put anything in mouth.
- Note time – Start & End
- Once seizure is finished, put in recovery position after checking Airway-Breathing-Circulation (ABC) is normal.

Known Epilepsy

FIRST AID + CALL FOR HELP/Blood Glucose Level

Notify Duty Doctor

Seizure continues more than 5 minutes or serial convulsive seizures

Basic Life Support if ABC is Abnormal

Injured during seizure or you believe they need urgent medical attention

Give IV or Rectal Diazepam or Oral Midazolam drops

Call Ambulance (999) or CRASH Team as per inpatient site protocol for medical emergencies

Liaise with Specialist Services for a review of Epilepsy Care Plan and Medication

Full Physical Health Examination and Investigations

Review all Psychiatric Medication and Care plans

Nursing staff to request OT carry out a bathing assessment if remaining on ward

Liaise with Specialist Services for a review of Epilepsy Care Plan and Medication
1. Flowchart three

Community staff actions New Seizure

Step 1 - Emergency

All Seizures – First or Known Epilepsy or Suspected Pseudo-seizures (unknown)

FIRST AID/Call for Help/Blood Glucose if kit available

Basic Life Support if ABC is Abnormal

Call Ambulance (999)

Step 2 – After care

- Type 1: Loss of Awareness, Shaking or Jerking, Fall to floor, Go still, tongue bites, wet themselves
- Type 2: Awareness preserved, Confused, Unusual behaviours – plucking at clothes, smacking of lips, swallowing or walking around.

- Be calm, stay with them until fully recovered.
- Look around for any dangers
- Cushion head, don’t hold them down, don’t put anything in mouth.
- Note time – Start & End
- Once seizure is finished, put in recovery position after checking Airway-Breathing-Circulation (ABC) is normal.

- First Seizure
- Seizure continues more than 5 minutes
- Injured during seizure
- You believe they need urgent medical attention

- Primary Epilepsy
- Fever
- Head injury, Brain infection or Stroke
- Substance misuse or medication related
- Electrolyte imbalance/Low BM
- Eclampsia

- Referral to Specialist by GP within 14 days of first seizure for, full physical health examination, clinical history, diagnosis & investigations, Neuro-psychology (for LD or Cognitive difficulties)
- Stop Driving until Specialist Assessment
- Avoid potentially dangerous work or leisure activities – swimming/bath unsupervised
- Advise and Essential information about Epilepsy, how to recognise, manage and give first aid.
- Awareness of triggers
1. Flowchart four

Community Staff actions people with diagnosed epilepsy

- Type 1: Loss of Awareness, Shaking or Jerking, Fall to floor, Go still, tongue bites, wet themselves
- Type 2: Awareness preserved, Confused, Unusual behaviours – plucking at clothes, smacking of lips, swallowing or walking around.

- Be calm, stay with them until fully recovered.
- Look around for any dangers
- Cushion head, don’t hold them down or move them unless in danger, and don’t put anything in mouth.
- Note time – Start & End of fit
- Once seizure is finished, put in recovery position after checking Airway-Breathing-Circulation (ABC) is normal.

Known Epilepsy

FIRST AID + CALL FOR HELP
blood glucose if kit available

Seizure continues more
than 5 minutes or serial
convulsive seizures

Basic Life Support if ABC
is Abnormal

Oral Midazolam or Rectal
Diazepam for status
epilepticus as indicated in
Epilepsy care plan.
Medication is available with
patient & staff trained to
deliver it

Injured during seizure
OR you believe they
need urgent medical
attention

Follow Epilepsy Care Plan with
GP and Specialist Input OR If no
Epilepsy Care Plan refer to GP
for review
Inform carers to support patient
at home

Call Ambulance (999)
2. Introduction

2.1 Epilepsy is a common neurological disorder characterised by recurring seizures. Mortality due to epilepsy is of significant concern as patients with epilepsy have a mortality rate significantly higher than that of the general population. The standardized mortality rate (SMR) is shown to be 1.6-9.3 times higher in this population (Cockrell et al, 1994).

2.2 It is estimated that 20-30% of patients with epilepsy also have psychiatric disturbances (Vuilleumier & Jallon 1998) and hence, it important for us as health professionals to be well-versed with managing this condition.

2.3 Epilepsy is defined as “a disease of the brain defined by any of the following conditions:

1. At least two unprovoked (or reflex) seizures occurring >24 h apart
2. One unprovoked (or reflex) seizure and a probability of further seizures similar to the general recurrence risk (at least 60%) after two unprovoked seizures, occurring over the next 10 years
3. Diagnosis of an epilepsy syndrome.

2.4 Epilepsy is considered to be resolved for individuals who had an age-dependent epilepsy syndrome but are now past the applicable age or those who have remained seizure-free for the last 10 years, with no seizure medicines for the last 5 year” (Fisher et al, 2014).

2.5 Epidemiology

2.5.1 Epilepsy has been estimated to affect between 362,000 and 415,000 people in England. In addition, there will be further individuals, estimated to be 5–30%, so amounting to up to another 124,500 people, who have been diagnosed with epilepsy, but in whom the diagnosis is incorrect.

2.5.2 Incidence is estimated to be 50 per 100,000 per year and the prevalence of active epilepsy in the UK is estimated to be 5–10 cases per 1000.

2.5.3 Accurate estimates of incidence and prevalence are difficult to achieve because identifying people who may have epilepsy is difficult (NICE, 2012), as epileptic seizures can be caused by different reasons, e.g. head injury, alcohol withdrawal, etc.; and also as different types of epilepsy have different causes.

2.6 Seizure classification

2.6.1 The International League Against Epilepsy (ILAE) is a world-wide organisation of epilepsy professionals and in 2017 they announced a different way of organising and naming seizures Tucker et al, 2017a: Tucker et al, 2017b).
2.6.2 The seizures are classified according to:

1. **Where the seizure starts (the onset)** - Seizures can be either focal onset, generalised onset, or unknown onset.

   a. **Focal onset** - Focal onset means the seizure starts in just one side of the brain. These seizures used to be called partial seizures. Sometimes, a seizure can start as a focal seizure and then spread to involve both sides of the brain. When this happens, it's called a focal to bilateral tonic-clonic seizure.

   b. **Generalised onset** - Generalised onset means the seizure affects both sides of the brain from the start.

   c. **Unknown onset** - Unknown onset means the beginning of the seizure is not clear. As doctors get more information about the seizure, they may be able to decide if it is focal or generalised in onset.

   d. On rare occasions it is unclear what type of seizure a person experiences. These are known as **unclassified seizures**.

2. **The level of awareness** - Generalised onset seizures almost always affect awareness in some way, so the terms ‘aware’ or ‘impaired awareness’ aren’t used for them. Focal onset seizures can be put into one of 2 groups depending on what level of awareness during the seizure.

   a. **Focal aware** - During a focal aware seizure, the person is fully aware of what’s happening, even if unable to talk or respond. These seizures were previously defined as simple partial seizures.
b. **Focal impaired awareness** - If awareness is affected at any time during a focal seizure, it’s defined as a focal impaired awareness seizure. This replaces the term complex partial seizure.

3. **Whether the seizure involves movement or not** - Seizures can also be split into motor seizures, which means they involve movement, or non-motor seizures, which means they don’t involve movement.
   a. **Motor seizures** - A motor seizure is any seizure that involves a change in movement. For example, a tonic-clonic seizure – where all muscles stiffen followed by rhythmic jerking movements – is a type of motor seizure. Focal seizures can also be motor seizures if the main symptom involves movement, for example automatic behaviour like plucking at clothes or repeated swallowing.
   b. **Non-motor seizures** - A non-motor seizure is any seizure that doesn’t involve changes in movement. A focal seizure where the main symptom is a change in vision, smell or hearing is a type of non-motor seizure. Absence seizures are also non-motor seizures.

2.7 **Pseudo or Dissociative seizures**

2.7.1 A pseudo or dissociative seizure is known by different names. They are commonly mistaken for epilepsy and can be difficult to diagnose, even for experienced doctors, as they can be very similar to epilepsy. They can be wrongly diagnosed and treated with medication, which might not work for their seizures. They are however, a real medical condition and can be just as disruptive and unsettling as epileptic seizures. They happen due to psychological reasons which include thoughts, feelings about the present and past experiences. It is important to keep in mind that Epileptic patients can have a combination of real and dissociative seizures and that all seizures should be investigated.

2.8 **Mortality and morbidity**

2.8.1 We already know that patients with epilepsy have a mortality rate significantly higher than that of the general population.

2.8.2 Nevalainen and colleagues (2014) in their literature review, which excluded studies of people with learning disability and those who had had surgery to treat epilepsy, found that excess mortality was highly related to the aetiology of epilepsy in all ages.

2.8.3 In adult patients without neuro-radiological abnormalities or other identifiable cause of epilepsy, only patients with cryptogenic epilepsy exhibited excess mortality. Risk of premature death was lowest in idiopathic epilepsy and in PWE who attained seizure freedom.
2.9 Psychiatric problems in people with epilepsy

2.9.1 It is estimated that around 70% of people who experience intractable complex partial seizures, may have one or more diagnoses consistent with the Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition (DSM-III-R); 58% have a history of depressive episodes, 32% have agoraphobia without panic or other anxiety disorder, and 13% have psychoses (Tucker, 1998).

2.9.2 The risk of psychosis in patients with epilepsy may be 6-12 times that of the general population, with a prevalence of about 7-8%, and in patients with treatment-refractory temporal lobe epilepsy, the prevalence has been reported to range from 0-16% (Torta & Keller, 1999). Vuilleumier and Jallon (1998) found that 2-9% of patients with epilepsy have psychotic disorders.

3. Aims and objectives

3.1 The policy aims to set the standards for management of Epileptic seizures in line with all relevant NICE standards and guidance.

3.2 The policy aims to ensure that any person in our care who experiences a seizure is appropriately supported and investigated, and receives evidence based treatment and care both in first episode of seizure and if there is already a diagnosis of epilepsy.

3.3 It sets out the expectations of interventions that should be provided by staff employed within WLMHT, and those that require advice and / or intervention from other specialist services.

3.4 The policy aims to ensure that risk assessments specific to people with epilepsy or those who experience seizures are completed in order to reduce risks of injury or ill health.

3.5 Underpinning this policy is the recognition that appropriate equipment, education and training are required and provided to enable staff to provide high quality treatment and care.

4. Scope

4.1 This policy applies to all staff employed or contracted to work within WLMHT in a clinical or managerial role.

4.2 It applies to all service users receiving care from WLMHT both in the community and inpatient services.

4.3 The level of input and interventions vary according to clinical settings as detailed in the flow charts.
5. **Duties**

5.1. **The Board**

5.1.1 The Board has a duty to ensure that physical healthcare is represented at board level (Royal College of Psychiatrists, 2016).

5.1.2 It has a duty to ensure (through performance monitoring of clinical outcomes) that all appropriate care is provided for those people who are long term residents of the Trust, and for whom the Trust is the only provider of health care.

5.1.3 The Board has a duty to ensure (through performance monitoring) that there is effective communication between the Trust and primary care services, for those service users for whom the Trust provides mental health care, but is not the sole responsible provider of physical health care.

5.1.4 The Board has a duty to ensure (through performance monitoring and leadership) the implementation of national public health policies that will improve the health outcomes of the vulnerable population groups for which the Trust provides mental or physical health care.

5.1.5 The Board has a duty to ensure that sufficient resources are available so that physical health care services can be delivered to a level that is clinically safe, and will deliver the outcomes that are required in this policy.

5.2 **The Accountable Directors**

5.2.1 The Medical Director and the Director of Primary Care are the accountable directors. They are responsible for establishing the standards for seizure care monitoring within the organisation and seeking advice from relevant specialists as required.

5.2.2 The Physical Health Consultant Nurse will:

- Support services in operationalising the Seizures policy.
- Support services on the management of seizure care for service users.
- Identify, develop and work with Learning and Development and the nursing and medical directorates to develop competency requirements of clinical and non-clinical staff to ensure that they are competent to manage people who present with seizures.

6 **Management of seizures**

6.1 The first step in management of seizure is to recognise when someone is having a seizure. In general, seizures can present in two ways, although it can vary according to the individual and the type of epilepsy they have.

6.2 Tonic-clonic (convulsive) or generalised seizures are sometimes referred to as grand mal seizures. Someone having a tonic-clonic seizure goes stiff, loses consciousness, falls to the floor and begins to jerk or convulse. They may become
pale or go blue around the mouth due to irregular breathing. Sometimes they may lose control of their bladder or bowels, and bite their tongue or the inside of their mouth.

6.3 Focal Seizures or partial seizure may or may not be aware of their surroundings or what they are doing, according to the kind of seizure. They may have unusual movements and behaviour such as plucking at their clothes, smacking their lips, swallowing repeatedly or wandering around, unusual sensations or intense emotions such as fear or joy.

6.4 General Management of Tonic-Clonic Seizures: - FIRST AID.

Do:
- Protect them from injury (remove harmful objects from nearby)
- Cushion their head
- Time how long the jerking lasts
- Aid breathing by gently placing them in the recovery position once the jerking has stopped (see picture)
- Stay with the them until they are fully recovered
- Be calmly reassuring

Don't:
- Restrain their movements
- Put anything in their mouth
- Try to move them unless they are in danger
- Give them anything to eat or drink until they are fully recovered
- Attempt to bring them round

6.5 General Management of Non-Tonic Clonic Seizures

6.5.1 Simple Partial Seizures - Although the person is awake and aware, simple partial seizures can feel unsettling so giving gentle reassurance may be helpful.

6.5.2 Complex Partial Seizures - the person’s consciousness is affected and they may be confused. You might notice them wandering around or behaving strangely and they may not know what they are doing. This might last a few seconds to a few minutes.
The following outlines a few steps -

1. Do not restrain the person as this may upset or confuse them.
2. Gently guide the person away from any danger.
3. Speak quietly and calmly so that so that the person is not startled. The individual may be confused, and speaking loudly or acting forcefully this may worsen confusion. The person may misinterpret help as hostility and become upset or respond in an aggressive way.
4. After the seizure stops:
   - The person may feel tired and need to sleep.
   - It may help if you remind the person where he or she is because the person may not be fully aware of their surroundings.
   - Stay with the person until fully recovered and can safely return to what they were doing.

6.6 General Management of Secondary Generalised Seizures

6.6.1 Secondary Generalized Seizures occur when patients who start with having Partial Seizures and then develop into a generalised tonic clonic seizure. When this happens they become unconscious. Some people call their partial seizure a warning or aura.

6.6.2 If the person is aware of a warning, they may need help to make themselves safe before the generalized seizure starts. If the person develops a generalized seizure follow the protocol above.

6.7 Management of Other Generalised Seizures - Stay with the person and, if necessary, gently guide them away from any danger.

6.7.1 Absence or Petit Mal Seizures - During an absence the person becomes unconscious for a short time, usually a few seconds. They may look blank and not respond to what is happening around them. For example, if they are walking they may continue to walk, but will not be aware of what they are doing.

6.7.2 Tonic & Atonic Seizures - In a tonic seizure the person’s muscles suddenly become stiff. If they are standing they often fall backwards and may injure the back of their head. In an atonic seizure (also called a ‘drop attack’) the person’s muscles suddenly relax, and they become floppy.

6.7.3 Myoclonic seizures - involve jerking of a limb or part of a limb, and often happen shortly after waking up from sleep. They are brief and can happen in clusters with many happening close together in time.

6.8 Prolonged seizures – If a tonic-clonic seizure is prolonged or recurrent, the patient may be given prescribed emergency treatment. In an inpatient setting, while first aid is being administered, the ward or duty doctor is to be informed and rescue medication can be administered if appropriate. Emergency admission to an acute hospital will be arranged if seizures do not respond promptly to treatment.
6.9 Provoked seizures

6.9.1 Seizures are classified as provoked or unprovoked.

6.9.2 An acute symptomatic seizure is one that occurs following a recent acute disorder such as a metabolic insult, toxic insult, central nervous system infection, stroke, brain trauma, cerebral haemorrhage, medication toxicity, alcohol withdrawal, or drug withdrawal. E.g. Seizure that occurs within 1 week of a stroke or head injury. Studies have reported that 25-30% of first seizures are acute symptomatic seizures (Benbadis, 2009).

6.9.3 An unprovoked seizure is a cryptogenic or a remote symptomatic seizure that occurs longer than 1 week following a disorder that is known to increase the risk of developing epilepsy. These disorders may produce static or progressive brain lesions. E.g. Seizure that first occurs 6 months following a traumatic brain injury or stroke (Benbadis, 2009). Table x provides some instances and details of management.

6.9.4 Table 1: Identification and management of provoked seizures (SIGN, 2015)

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<th>Metabolic disturbances/drugs</th>
<th>Correct or withdraw the provocative factor.</th>
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<tr>
<td>Alcohol or substance misuse</td>
<td>Patients may benefit from referral to addiction services or other support agencies</td>
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<td>Acute brain insult/neurosurgery</td>
<td>Long-term prophylactic AED treatment is not indicated.</td>
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<tr>
<td>Following an acute brain insult,</td>
<td>Withdraw AEDs used to treat provoked seizures (unless unprovoked seizures occur later).</td>
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<tr>
<td>Concussive convulsions</td>
<td>AED treatment is not indicated.</td>
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6.10 Management of Seizures – Inpatient & Community

6.10.1 Clinicians and Health Professionals: Inpatients

6.10.1.1 The ward or duty doctor is responsible for ensuring that people suspected of having a first epileptic seizure should be referred to a specialist for confirmation of the diagnosis and initiation of treatment (NICE, 2017).

6.10.1.2 The ward or duty doctor is responsible for prescribing rescue medication for prolonged seizures in people with a diagnosis of epilepsy. NICE (2012) guidance recommends buccal midazolam as the first line treatment for prolonged/serial convulsive seizures.

6.10.1.3 The Service User must be included in the decision making process around deciding on the use of rescue medication and consent to its use sought and recorded when the person is deemed to have capacity. If there are concerns about capacity, adequate provisions under the Mental Capacity Act 2005 and Best Interests decision will apply in use of preventative medication.

6.10.1.4 Prescribers must be aware of potential contraindications to the use of rescue medication e.g. respiratory problems.
6.10.1.5 The prescriber must provide clear guidance for the use of rescue medication in prolonged convulsive seizures. This guidance should include the following:

1. Name and dose of medication prescribed and route of administration.
2. Maximum dose in 24 hours.
3. Time allowed between doses.
4. When to give medication e.g. a generalized tonic clonic seizure lasting five minutes or more.
5. Time to allow for drug to take effect.
6. Details of any second dose – when to give and time to allow for drug to take effect (in certain cases).

6.10.1.6 The Responsible Clinician (RC) will ensure that those who have a diagnosis of epilepsy attend a routine review at least once a year to assess:

- Seizure control, adverse effects and compliance with treatment, and appropriate antiepileptic drug prescribing.
- The impact of epilepsy on work, education, and leisure activities, and how to manage risks.
- Entitlement to drive.
- Carers’ skills in managing seizures, including how and when to give emergency buccal midazolam, if appropriate.
- Contraception needs and pregnancy planning information needs, if appropriate.

6.10.1.7 The RC will ensure that specialist advice is sought for a person with confirmed epilepsy with:

- Poor seizure control or poorly tolerated treatment.
- Previous prolonged or recurrent seizures, which have not been prescribed emergency treatment for use in the community, if appropriate.
- Possible new cognitive impairment

6.10.1.8 The RC to ensure that for female patients of child-bearing age with established diagnosis of Epilepsy confirmed by a Specialist and Valproate is being considered or is already prescribed as the anti-epileptic medication the following steps are adhered to:

- A blood test to confirm the pregnancy status of the patient on admission.
- Patient to be made aware of the risks of continuing Valproate while pregnant and also risks of not using PREVENT pregnancy prevention measures – highly effective contraception.
- If pregnant, RC to liaise with Specialist regarding medication and consider alternatives to Valproate, if feasible. Patient to be made aware of the discussion and urged to continue medications already prescribed until advised.
- If the patient is in agreement to continue with Valproate, RC to ensure that the Valproate Annual Risk Acknowledgement Form is completed and signed by patient and RC and scanned/uploaded onto the patient’s notes. This needs to be done within 24 hours of admission.
- Patient advised to adopt using PREVENT pregnancy prevention measures while on Valproate as highly effective contraception.
- The detail of the discussion should be recorded in the patient’s clinical notes and should be part of continued discussion in ward rounds.
• If the completed form is available from GP surgery, ward doctor or pharmacist to ensure that this is sourced and uploaded on patient’s clinical notes.
• The discussion about continuing with the Valproate should then be part of the ward round and again the Annual Risk Acknowledgement Form renewed.
• Ward Pharmacist to ensure that Valproate is dispensed only once the Valproate Annual Risk Acknowledgement Form is completed.

6.10.1.9 All clinical staff will have the ability to recognise and safely manage a seizure.

6.10.1.10 Nursing staff will carry out a risk assessment related to bathing (appendix two) ensure that a person who has seizures is referred to the occupational therapy department so that a specialist bathing assessment (appendix three) can be carried out. The person’s care plan must include details about seizures relevant to the individual, such as known triggers, usual length of seizure, mental state during recovery, treatment options, a bathing assessment and how any identified risks such as bathing will be managed. It will have details of professionals involved and Epilepsy care plan if available.

6.10.2 Clinicians and Health Professionals: Outpatients or Community

6.10.2.1 The GP is responsible for ensuring that people suspected of having a first epileptic seizure should be referred to a specialist for confirmation of the diagnosis and initiation of treatment (NICE, 2017).

6.10.2.2 The GP is responsible for prescribing rescue medication for prolonged seizures in people with a diagnosis of epilepsy and this should be specified on the person’s Epilepsy care plan.

6.10.2.3 The Service User must be included in the decision making process around deciding on the use of rescue medication and consent to its use sought and recorded when the person is deemed to have capacity. If there are concerns about capacity, Mental Capacity Act 2005 and Best Interest Decisions can be considered in use of preventative medication.

6.10.2.4 NICE (2012) guidance recommends buccal midazolam as the first line treatment for prolonged/serial convulsive seizures. This rescue medication should be specified in the service users Epilepsy Care Plan and be provided at home if appropriate by the GP.

6.10.2.5 Rescue Medication (buccal Midazolam or rectal Diazepam) should be administered by appropriately trained staff and only if service user is having prolonged or serial convulsive seizures.

6.10.2.6 The GP will ensure that those who have a diagnosis of epilepsy attend a routine review at least once a year to assess:
  • Seizure control, adverse effects and compliance with treatment, and appropriate antiepileptic drug prescribing.
• The impact of epilepsy on work, education, and leisure activities, and how to manage risks.
• Entitlement to drive.
• Carers’ skills in managing seizures, including how and when to give emergency buccal midazolam, if appropriate.
• Contraception needs and pregnancy planning information needs, if appropriate.

6.10.2.7 **The GP** will ensure that specialist advice is sought for a person with confirmed epilepsy with:
• Poor seizure control or poorly tolerated treatment.
• Previous prolonged or recurrent seizures, who have not been prescribed emergency treatment for use in the community, if appropriate.
• Possible new cognitive impairment

6.10.2.8 **Community Clinicians** to work alongside **GPs** to ensure that for female **patients of child-bearing age** with established diagnosis of Epilepsy confirmed by a Specialist and Valproate is being considered or is already prescribed as the anti-epileptic medication, the following steps are adhered to:
• GP to get baseline blood test to confirm the pregnancy status of the patient prior to initiating Valproate and to monitor while continuing on it.
• Patient to be made aware of the risks of continuing Valproate while pregnant and also risks of not using PREVENT pregnancy prevention measures – highly effective contraception.
• If pregnant, Community clinician to inform GP who would liaise with Specialist regarding medication and consider alternatives to Valproate, if feasible. Patient to be made aware of the discussion and urged to continue medications already prescribed until advised.
• If the patient is in agreement to continue with Valproate, GP to ensure that the Valproate Annual Risk Acknowledgement Form is completed and signed by patient and GP. Community Clinicians to source this from GP surgery and scan/upload onto the patient’s notes.
• Patient to be given information about PREVENT pregnancy prevention measures and encouraged to consider highly effective contraception.
• Community Clinicians to record the discussions and steps taken to ensure patient safety when prescribing Valproate in the patient’s clinical notes.
• Community Clinicians to ensure that this is discussed at every clinical review with patient.

6.10.2.9 **All clinical staff** will have the ability to recognise and safely manage a seizure.

6.10.1.10 **Nursing staff** will ensure that the person’s care plan includes details about seizures relevant to the individual, such as known triggers, usual length of seizure, mental state during recovery, treatment options, details of professionals involved and Epilepsy care plan if available.
7. The importance of effective management of Epilepsy

- People with epilepsy have an increased risk of premature death and most premature deaths in this population are directly related to epilepsy itself.
- Approximately 1000 people per year die because of epilepsy and most of these deaths are associated with seizures.
- Sudden Unexpected Death in Epilepsy (SUDEP) is associated with chronic epilepsy – approximately 500 deaths per year in the UK. The cause of SUDEP is unclear, but the most important risk factor is the occurrence of seizures and the more frequent the seizures, the higher the risk (Hanna et al, 2002).
- Epilepsy leads to 400 avoidable deaths per year in the UK.
- 69,000 people living with unnecessary seizures in the UK.
- 74,000 people taking drugs they do not need in the UK.
- £189million is needlessly spent each year (All Party Parliamentary Group on Epilepsy Inquiry 2007).

8. Women of childbearing age who have Epilepsy

8.1 Women of child bearing potential require specific management in relation to:
- Conception (pre-conception counselling) plus consideration of folic acid use
- Pregnancy
- Risk of Epilepsy and Anti-Epilepsy Drugs (AEDs) to unborn child
- Valproate & Contraception
- Giving Birth & Care of child
- Breast feeding
- Menopause & Osteoporosis

8.2 Conception:

- **Preconception counselling** - It is the opportunity to talk through all aspects of the epilepsy treatment prior to becoming pregnant, so that you can plan your treatment, type and dose of medication, learn about how seizures could affect pregnancy and how it could affect the unborn child. Because women with epilepsy have a slightly higher risk of complications, forward planning can help keep these risks to a minimum.
- It is important **not** to stop taking AEDs suddenly and without the medical guidance of your neurologist or GP.
- The woman (and her family) are likely to be advised to keep taking AEDs throughout the pregnancy - as seizures during pregnancy can result in injury to mother and baby and this risk could be deemed higher (depending on the type
and frequency of seizures you have) than the risk of the AEDs affecting your baby.

- Women with epilepsy are strongly recommended to take a higher dose of folic acid (5mg) daily, as soon as they start trying for a baby and for at least the first 16 weeks of their pregnancy, or for the whole pregnancy if their doctor feels this is appropriate.

8.3 Pregnancy:

- Pregnancy may affect seizures or the effectiveness of AED medication.
- Most women with epilepsy do not have any change in their seizure frequency during pregnancy.
- During pregnancy the body may use up more AEDs than usual and hence, the amount of AED normally taken may not be enough to stop seizures from happening. This can be monitored using blood tests.
- With morning sickness, if the woman is sick after taking AEDs, the medication may not have a chance to work properly. Changing the time of day you take your AEDs, for example taking them when you’ve stopped feeling sick, may be helpful.
- Risk during pregnancy – injury during seizures, tonic clonic (convulsive) seizures could potentially cause miscarriage or serious harm to mother and baby. In rare cases, women with epilepsy have died during pregnancy.
- Some AEDs can affect how the baby grows and develops in the womb, particularly so in the first 12 weeks of pregnancy when the baby’s main organs and skeleton are developing.

8.4 Risk of Epilepsy and Anti-Epilepsy Drugs (AEDs) to unborn child:

- Most women with epilepsy will have a normal pregnancy and labour and over a 9 in 10 (90%) chance of having a healthy baby.
- Women with epilepsy have a slightly higher chance of having a baby with a birth defect due to genetic conditions, injury during seizures and anti-epileptic drugs (AEDs).
- Minor malformations are those that do not need surgery, for example small fingers and toes, and eyes set wide apart.
- Major malformations are those that need surgery to correct them - a hole in the heart, problems with the kidneys or genitals, cleft lip and cleft palate, and problems with the development of the spine and nervous system (neural tube defects), such as spina bifida (where part of the spinal cord is exposed). Sometimes the child’s arms, legs, or the way their face looks, may also be affected.
- Women with epilepsy who take anti-epileptic drugs (AEDs) during pregnancy also have a slightly higher risk than women with epilepsy who don't take AEDs.
- Taking more than one AED increases the risks, especially if this includes Valproate.
- **Fetal anti-convulsant syndrome** - Some AEDs are thought to affect a child’s development after they are born. This is called fetal anti-convulsant syndrome (FACS). The risk of this happening appears to be higher with sodium valproate than with other AEDs. Problems with the child’s development and learning can include: delayed walking and talking, poor speech and language, and problems with memory, attention, lower intelligence and behaviour. Often these effects
are not seen until the child starts to get older, for example when they start nursery or school.

- Folic acid (vitamin B9) helps a developing baby’s spine to form and reduces the risk of neural tube defects, such as spina bifida.

8.5 Valproate & Contraception:

- Valproate is an effective treatment for epilepsy (and Bipolar Affective Disorder).
- Valproate however, is associated with a high risk of congenital abnormalities and developmental disorder.
- In girls and women of childbearing potential valproate must be initiated and supervised by a specialist experienced in the management of epilepsy (or bipolar disorder).
- Valproate should not be used in girls and women of childbearing potential unless other treatments are ineffective or not tolerated.
- Valproate may be initiated in girls and women of childbearing potential only if the conditions of **prevent** – the valproate pregnancy prevention programme are fulfilled. (DOH, 24 April 2018). In February 2016 the MHRA had issued guidance in relation to prescribing Valproate for women of childbearing age and circulated leaflets to support discussion of these risks with women of childbearing potential and girls who take valproate.
- Children exposed in utero to Valproate are at a high risk of serious developmental disorders (in up to 30-40% of cases) and congenital malformations (in approximately 10% of cases).
Prevent – Valproate Pregnancy Prevention Programme:

- A woman of childbearing potential is defined as a pre-menopausal female who is capable of becoming pregnant.
- These conditions also concern women who are not currently sexually active unless the prescriber considers that there are compelling reasons to indicate that there is no risk of pregnancy.
- Individual circumstances should be evaluated in each case, involving the patient in the discussion, to guarantee her engagement, discuss therapeutic options and ensure her understanding of the risks and the measures needed to minimise the risks.
- Highly effective contraception is considered for regulatory purposes to be those user independent methods such as the long acting reversible contraceptives (LARC), copper intrauterine device (Cu-IUD), levonorgestrel intrauterine system (LNG-IUS) and progestogen only implant (IMP) and female sterilisation, all of which have a failure rate of less than 1% with typical use.
- User dependent methods such as the condom, cap, diaphragm, combined oral contraceptive pill (COC) or progestogen-only contraceptive pill (POP) and fertility awareness based methods are not considered highly effective since the typical use incorporates user failure risks.

**Specialists**
- Discuss the risks with the patient (or parent/caregiver/responsible person)
- Exclude pregnancy in women of childbearing potential (by serum pregnancy test) before the first prescription is issued
- Arrange for highly effective contraception for women of childbearing potential before the first prescription is issued
- Complete the Annual Risk Acknowledgment Form (Check Appendix) with patient (or parent/caregiver/ responsible person); give them a copy and send a copy to the GP
- See the patient urgently (within days) if referred back in case of unplanned pregnancy or if she wants to plan a pregnancy
- Provide a copy of the Patient Guide to the patient (or parent/caregiver/responsible person)

**General practitioners**
- Ensure continuous use of highly effective contraception in all women of childbearing potential (consider the need for pregnancy testing if not a highly effective method)
- Check that all patients have an up to date, signed, Annual Acknowledgment of Risk Form each time a repeat prescription is issued
- Ensure the patient is referred back to the specialist for review, annually
- Refer back to the specialist urgently (within days) in case of unplanned pregnancy or where a patient wants to plan a pregnancy.

- For children or for patients without the capacity to make an informed decision, provide the information and advice on highly effective methods of contraception and on the use of valproate during pregnancy to their parents/caregiver/responsible person and make sure they clearly understand the content
8.6 Keeping in line with DOH May 2018 and up-to-date MHRA guidance, the Trust policy is – **Valproate is contraindicated in women of childbearing potential unless the conditions of prevent – the valproate pregnancy prevention programme are fulfilled.**

8.6.1 Existing female patients:

- Identify all women of childbearing potential on valproate
- Recall any women who may be of childbearing potential and arrange for contraception if not already using contraception
- Inform her of the known risks and ensure that she understands she must not get pregnant whilst taking valproate
- Tell her to contact you immediately if she suspects there has been a problem with her contraception or she may be pregnant
- Refer to her specialist† (unless she has seen one recently and is on prevent)
- Arrange to see each woman of childbearing potential after specialist review and ensure she is on prevent, i.e. ensure that: • she has the Patient Guide and has a copy of the Annual Risk Acknowledgment Form signed by the specialist • You file a copy of the signed Annual Risk Acknowledgment Form in her medical records
- She is using contraception and understands the need to comply with contraception throughout treatment and undergo pregnancy testing when required – e.g. if there is any reason to suggest lack of compliance or effectiveness of contraception
- Remind her that she will need to see her specialist at least every year while taking valproate medicines and arrange for referral as necessary.

8.6.2 New female patient – women of childbearing potential:

- Refer her to the relevant specialist for diagnosis and to initiate treatment if appropriate
- Arrange to see each woman of childbearing potential after specialist review and, if on valproate, ensure she is on prevent.
- She has the Patient Guide and has a copy of the Annual Risk Acknowledgment Form signed by the specialist, and file a copy of the form in her medical records
- You file a copy of the signed Annual Risk Acknowledgment Form in her medical records
- She is using contraception and understands the need to comply with contraception throughout treatment and undergo pregnancy testing when required – e.g. if there is any reason to suggest lack of compliance or effectiveness of contraception
- Remind her that she will need to see her specialist at least every year while taking valproate medicines and arrange for referral as necessary
- Tell her to contact you immediately if she suspects there has been a problem with her contraception or she may be pregnant.

8.6.3 Women of childbearing potential who are planning to become pregnant:

- Inform her not to stop contraception or valproate until told to by her specialist
- Refer to the specialist who is managing her condition.
8.6.4 **Patient with unplanned pregnancy:**

- Inform her not to stop valproate
- Refer her to a specialist and ask for her to be seen urgently (within days).

8.7. **Actions for specialist prescribers**

“Specialist prescriber is defined as a consultant psychiatrist or a consultant neurologist who regularly manages bipolar disorder or complex epilepsy”

8.7.1 **Existing female patients**

- Review women who may be of childbearing potential
- Continue treatment with valproate only if other treatments are ineffective or not tolerated and pregnancy is excluded by means of a negative pregnancy test
- Discuss the need for her to be on the prevent programme if she is to continue taking valproate:
- Ensure she understands the risks to the unborn child of using valproate during pregnancy and provide the Patient Guide
- Ensure she understands the need to comply with contraception throughout treatment and undergo pregnancy testing when required – e.g. if there is any reason to suggest lack of compliance or effectiveness of contraception
- Complete and sign the Annual Risk Acknowledgment Form (at initiation and every annual visit); give a copy to her and send one to her GP
- Refer for contraception services as needed
- Ensure that you invite all women on prevent for an annual review.

8.7.2 **New female patient – women of childbearing potential**

- Start treatment with valproate only if other treatments are ineffective or not tolerated and pregnancy is excluded by means of a negative pregnancy test
- Assess potential for pregnancy and if necessary discuss the need for her to be on the prevent programme if she is to take valproate:
- Ensure she understands the risks to the unborn child of using valproate during pregnancy and provide the Patient Guide
- Ensure she understands the need to comply with contraception throughout treatment and undergo pregnancy testing when required – e.g. if there is any reason to suggest lack of compliance or effectiveness of contraception
- Complete and sign the Annual Risk Acknowledgment Form (at every annual visit); give a copy to her and send one to her GP
- Refer for contraception services as needed.
- Ensure that you invite all women on prevent for an annual review.

8.7.3 **Women of childbearing potential planning to become pregnant**

- Ensure she understands the risks of valproate in pregnancy
- Switch valproate to another therapeutic option
- Tell her not to stop contraception until the switch is achieved and she is no longer taking valproate
- If switching is not possible refer for counselling about the risks.
• Women presenting with an unplanned pregnancy should have their treatment switched
• Women with epilepsy who have to continue treatment in pregnancy (i.e. if switching to an alternative treatment is not possible) should be referred for appropriate monitoring.

8.8 Actions for pharmacists:
• Ensure the Patient Card is provided every time valproate is dispensed
• Remind patients of the risks in pregnancy and the need for highly effective contraception
• Remind patients of the need for annual specialist review
• Ensure the patient has received the Patient Guide
• Dispense valproate in the original package. In situations where repackaging cannot be avoided always provide a copy of the package leaflet and add a sticker with the warning to the outer box
• If a woman of childbearing potential reports that she is not taking highly effective contraception, refer them to their GP (including by contacting the GP if necessary).

8.9 Switching or discontinuing valproate – in Patients with epilepsy:
• Valproate is contraindicated in pregnancy unless there is no suitable alternative treatment. Valproate is contraindicated in women of childbearing potential unless the conditions of prevention – the valproate pregnancy prevention programme are fulfilled.
• If a woman is planning to become pregnant, a specialist experienced in the management of epilepsy must reassess valproate therapy and consider alternative treatment options.
• Every effort should be made to switch to appropriate alternative treatment prior to conception and before contraception is discontinued.
• If a woman becomes pregnant on valproate, she must be immediately referred to a specialist to consider alternative treatment options.
• Drug withdrawal is usually undertaken gradually over weeks to months, which allows an opportunity to identify the likely minimum required dose should a seizure occur during drug withdrawal."
• If, despite the known risks of valproate in pregnancy and after careful consideration of alternative treatment, in exceptional circumstances a pregnant woman must receive valproate for epilepsy: There is no dose threshold considered to be without any risk. However, the risk of birth defects and developmental disorders is higher at greater doses. Use the lowest effective dose and divide the daily dose of valproate into several small doses to be taken throughout the day. The use of a prolonged release formulation may be preferable to other treatment formulations in order to avoid high peak plasma concentrations
• All patients with a valproate exposed pregnancy and their partners should be referred to a specialist experienced in prenatal medicine.
8.10 Contraception:

- Highly effective contraception is considered for regulatory purposes to be those user independent methods such as the long acting reversible contraceptives (LARC), copper intrauterine device (Cu-IUD), levonorgestrel intrauterine system (LNG-IUS) and progestogen only implant (IMP) and female sterilisation, all of which have a failure rate of less than 1% with typical use.

- User dependent methods such as the condom, cap, diaphragm, combined oral contraceptive pill (COC) or progestogen-only contraceptive pill (POP) and fertility awareness based methods are not considered highly effective since the typical use incorporates user failure risks.

8.11 Giving Birth & Care of child:

- For 2 - 4 women in every 100 (2 - 4%) who have epilepsy, the stress of labour may trigger a tonic clonic seizure either during labour or during the 24 hours afterwards, even if they don't normally have tonic clonic seizures. Hence, doctors advise a hospital delivery.

- It can be useful for the midwife and medical team who will be at the birth to know about the epilepsy, including the type of seizures, which anti-epileptic drugs (AEDs) are prescribed and at what times.

- Ideally, AEDs are taken as normal during labour.

- After your baby is born - A very small number of newborn babies (about 0.01% or 1 in 10,000) are born without enough vitamin K. This can cause nose bleeds, mouth bleeds and in some cases, internal bleeding. Some AEDs can reduce a mother's vitamin K levels, and this can increase the risk of their baby having low vitamin K levels.

- Keeping you and your baby safe: If seizures happen suddenly and without warning, the following ideas may be helpful to keep the baby safe. These might not always be necessary, especially if there is someone else around.

  - Dressing and changing your baby on the floor means they would be less likely to fall if you had a seizure.
  - Sponging your baby down on a changing mat on the floor is safer than bathing them in water.
  - Carrying your baby in a padded carrycot or sling rather than having them in your arms may help to protect your baby if you fall.
  - Using a wrist strap on your baby’s pram means that the pram will not roll away if you let it go.
  - Feeding your baby in a low highchair may be safer as it is less likely to tip over than a higher one.
  - Feeding your baby while you sit on the floor, surrounded by cushions and leaning against the wall may help to keep your baby safer.

8.12 Breastfeeding:

- The Department of Health recommends that every woman is encouraged to breastfeed her baby if at all possible. Breastmilk usually provides all the nutrients a baby needs for the first six months of their life.

- The baby will have become used to the drugs while in the womb. If breastfed, a small amount will be passed to the baby via breastmilk. Breastfeeding can be a
useful way of weaning the baby off the medication that they have become used to.

8.13 **Menopause & Osteoporosis:**

- Hormonal levels in women always changes with age and there might be a need to change dose of Epilepsy medication.
- Older women require specific management in relation to menopause and bone health treatment and management.
- HRT may increase the risk of seizures for some women. If this happens it might be helpful to discuss the HRT with your neurologist to consider possible alternatives or different combination of oestrogen and progestogen.
- Epilepsy and taking anti-epileptic drugs may contribute to the risk of developing osteoporosis for some people.
- There is a need for effective liaison between specialists, primary care and relevant mental health services.

9. **Risk assessment**

9.1 People with epilepsy are at greater risk of injury, drowning and are at risk of sudden unexpected death in epilepsy (SUDEP).

9.2 People with epilepsy are 15-19 times more likely to drown than the general population (Bell et al, 2008).

9.3 The individual with epilepsy may require specific risk assessments in relation to bathing or showering, cooking, using stairs, using public transport and swimming.

9.4 Risk assessment must include bathing and showering and environmental risks should be reduced (Neligan and Bell, 2015, and NICE, 2012).

*Appendices two and three provide details of risk assessment in relation to bathing. Appendix three provides details of occupational therapy assessment.*

10. **Capacity**

10.1 If people do not have the capacity to make decisions, professionals should follow the code of practice that accompanies the Mental Capacity Act (2005). Capacity should be clearly documented within the individual’s notes and care plan.

10.2 Capacity is decision specific and when a person lacks capacity to make a particular decision, the person should be involved as fully as possible in the decision.

10.3 A “best interests” decision is made which provides minimal restriction to the individual and allows them to fulfil their wishes as far as possible.

10.4 It is important that if the reason for the person’s lack of capacity is temporary this is revisited at the appropriate time.

10.5 If the individual does not have capacity to understand and make an informed decision regarding the risks associated with bathing, a best interest decision
should be made. If a best interest decision is required the appropriate people should be involved and the decision documented.

10.6 Care plans should be implemented to ensure safety at all times.

10.7 The individual should never be left alone whilst bathing and a clear discussion regarding showering held, documented and enacted.

- **If the individual has been assessed as having capacity and chooses to be supported to bath and shower** staff must ensure that they remain with the individual at all times.
- **If the individual has capacity and chooses NOT to be directly supported whilst bathing and/or showering** they are entitled to make what healthcare professionals would deem as an unwise decision.

10.8 This needs to be clearly documented. Staff should have discussions with the individual on a regular basis with regards to the risk and their views. Discussions and outcomes should be documented in notes, care plans and capacity assessments.

11 **Bathing and showering**

11.1 Showering - Having a shower can be safer than having a bath. However it does not totally eliminate all risk of injury and possible fatality. Consider the following:

- Keep drainage free from debris and running freely.
- Level access showers provide easier access, reduce the number of hard surfaces to fall against, such as the side of a bath, and do not allow the water to build up unlike a shower tray.
- A shower curtain, rather than a screen or door, makes it easier to reach someone quickly if they have a seizure in the shower, and prevents the risk of injury during a seizure.
- A wall mounted seat may help reduce injury as the distance to fall is reduced.

11.2 Bathing - If the person has capacity and choses to bathe:

- Staff must be present at all times with the person with epilepsy in their line of sight unless there is a clear documented and risk assessed reason otherwise.
- Run a shallow bath and put the water in before the person enters the bath.
- Ensure risk assessments are in place for any necessary equipment, for example, hoists, bath seats.
- Provide a non-slip mat within the bath to avoid slipping underwater.
- Ensure that it is possible to access plugs and quickly drain the bath in an emergency.
- Ensure the bath drains are clean and clear of debris so they can drain quickly.
- Where possible adjust any environmental factors such as lighting, noise and heat that may trigger a seizure.

11.3 **Actions in event of seizure in the bath:**

- Activate the call button/emergency alarm or call for help.
- Check the time if possible.
- Remain calm and reassure the individual by talking quietly and calmly.
- If seizure occurs whilst bathing support the individual’s head above the water.
- Remove the plug and allow the water to drain. Place a towel under the persons head if required to avoid any injury. Use a second towel to cover the person and continue to call for help. Do not move the person until the seizure ends.
- Check the time when the seizure ends.
- Administer Emergency Medication in line with prescribed protocol if required.
- Alert ward or duty doctor and request a visit.

12 Education and training

12.1 Medical staff: The protocol and training will be included and delivered through local academic programme and Junior Doctor's Handbook.

12.2 Nursing staff & all WLMHT staff: To be incorporated in ongoing nurse education programme and also as part of community team meetings. It is envisaged to provide this training as e-learning in time through the Learning and Development portal in the Trust.

12.3 People who have seizures can obtain information on safety advice by following the link below:
https://www.epilepsy.org.uk/info/daily-life/safety#bathroom

13. Inpatient Monitoring Requirements

13.1 The inpatient monitoring requirements will include the following

1. Detailed medical history and treatment history.
2. Full physical examination.
4. Relevant investigations.
5. Appropriate referral to specialist services and liaison with GPs and specialists.

14. Epilepsy and children & young people

14.1 All children and young people with recent onset seizures should be urgently referred to a Specialist to ensure early, precise diagnosis and treatment.

14.2 It is important to keep in mind that it can be difficult to diagnose epilepsy in children, young people with learning disabilities, and so care should be taken to obtain a full clinical history. Confusion may arise between stereotypic or other behaviours and seizure activity.
14.3 The Anti-Epileptic medication should be chosen in discussion with the young person and should be individualized according to seizure type, co-medication, co-morbidity and to the person’s life style.

14.4 Only administer Buccal Midazolam or rectal diazepam for intractable prolonged or repetitive seizures in the community.

14.5 Girls of child bearing age with Epilepsy should be given counselling about contraception, conception, pregnancy, caring for children and breast feeding. Valproate should not be considered first line management of epilepsy in girls of child-bearing age.

14.6 At reviews, young people should have access to written and visual information about epilepsy and the support systems available in the community.

14.7 The young person and their family or carers should have information on contacting the named person in case of need.

14.8 Behavioural or developmental regression or inability to identify the epilepsy syndrome in a child, young person or adult should result in immediate referral to tertiary services. They should have access to multi-disciplinary teams involved in managing complex epilepsy should include psychology, psychiatry, social work, occupational therapy, counselling, neuroradiology, clinical nurse specialists, neurophysiology, neurology, neurosurgery and neuro-anaesthesia. Teams should have MRI and video telemetry facilities available to them.

14.9 Psychological interventions (relaxation, cognitive behaviour therapy, biofeedback) may be used in conjunction with AED therapy in adults where either the person or the specialist considers seizure control to be inadequate with optimal AED therapy.

14.10 Refer children and young people with epilepsy whose seizures have not responded to appropriate AEDs to a tertiary paediatric epilepsy specialist for consideration of the use of a ketogenic diet.

15. Care planning and review

15.1 Each patient will have a care plan that addresses their identified physical health needs including epilepsy.

15.2 Staff will follow the escalation process in relation to NEWs as clinically indicated in the case of a seizure.

15.3 Discussion of physical health needs including seizure care will be included in the ward round, medication reviews and whenever there is a change in the service user’s Epilepsy status report.
15.4 Documentation that the service user's physical health needs including Epilepsy care have been considered and attended to will be documented in RiO following each ward round.

15.5 Discharge Requirements: At the point of discharge from inpatient services, any physical health including Epilepsy related abnormalities / findings should be shared as part of the discharge summary.

15.6 Role of Primary Care - The GP has primary responsibility for the management of epilepsy in outpatients and should ensure annual checks and regular updates. It is the GP’s responsibility to make appropriate referrals to specialist services.

16. Service user and carer participation

16.1 At all levels the lived in experience and expertise from service users and carers will be sought to improve and develop the provision of physical health services including Epilepsy care.

16.2 People admitted to inpatients will receive patient help physical healthcare record when these are introduced.

16.3 Provide general information about epilepsy and links to websites where service users can access information.

17. Monitoring and governance

17.1 Monitoring

17.1.1 The aim of this policy and associated procedures to ensure that service users receive appropriate assessment and evidence based treatment to the risks associated with seizures and epilepsy and experience improved health outcomes.

17.1.2 The Trust will conduct audits to monitor practice and outcome measures.  

Appendix 7 provides details of the audit which will be carried out annually

17.2 Governance: The annual audit will be reported to the physical health steering group and the Trust wide governance committee.

18. Fraud statement - N/A

19. Supporting documents

The following policies are those that relate to physical health care, and need to be reviewed and included in the terms of reference of the Physical Health Care Group:
• M2 medicines policy
• F3; First Aid
• B4; Basic Life Support
• F8; Prevention of inpatient falls and care and treatment of a patient following a fall or head injury
• M15: NEWS policy
• Infection control
• M9 Mental Capacity Act Policy

20. Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AEDs</td>
<td>Anti-epileptic drugs</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>CIG</td>
<td>Clinical Improvement Group</td>
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<td>CPA</td>
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</tr>
<tr>
<td>Consultant nurse physical healthcare</td>
<td>Nurse qualified to master’s level who has recognised qualifications in history taking, advanced physical assessment and diagnostic reasoning and prescribing.</td>
</tr>
<tr>
<td>NEWS</td>
<td>National Early Warning Score</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>RC</td>
<td>Responsible clinician</td>
</tr>
<tr>
<td>WLMHT</td>
<td>West London Mental Health Trust</td>
</tr>
</tbody>
</table>
21. References


- Neligan A and Bell G (2015) in Rugg-Gunn F and Smalls JE. *From channels to commissioning - a practical guide to epilepsy*, International League against epilepsy


- Essential SIGN 143 • Diagnosis and management of epilepsy in adults. SIGN, Healthcare Improvement, Scotland, Edinburgh [www.sign.ac.uk/assets/qrg143.pdf](http://www.sign.ac.uk/assets/qrg143.pdf)

# Appendix 1 - SEIZURE DESCRIPTION SHEET

**NAME:**

**DoB:**

<table>
<thead>
<tr>
<th>DATE OF SEIZURE</th>
<th>TIME OF START OF SEIZURE</th>
<th>WHERE DID THE PATIENT HAVE THE SEIZURE</th>
<th>SEIZURE OBSERVED AND RECORDED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LENGTH OF ACTUAL SEIZURE</th>
<th>APPROX RECOVERY TIME AFTERWARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe in your own words, what the person looked like/did prior, during and after the seizure:

<table>
<thead>
<tr>
<th>Was there anything which may have precipitated the seizure, e.g. Menstrual cycle, flashing lights, constipation, hypoglycaemia or infections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Please tick below to indicate what was happening to the person (or is thought to have happened) before, during and after the seizure.

## Before

Unusual sensation – e.g.

- taste / smell

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lethargy / tired</th>
<th>Change in skin colour (if yes what colour?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- "Witching"

- Very excited/ happy

- Anxious

- Change in appetite

- Racing heart/pulse

- Undressing

- Change in sleep pattern

- Scream / cry out

- Other -

## During

- The person became rigid

- Eyes closed

- Do they have involuntary jerky movements? If so

- The person became floppy

- Eyes open

- Change in breathing pattern

- Glazed / fixed stare

- Face

- Cold and sweaty

- Responds normally if talked to

- Whole body

- Colour of skin blue

- Doesn’t respond if talked to

- Left Arm

- Colour of skin red

- Unusual response if talked to

- Right Arm

- Mouth open

- Crying/weeping

- Left Leg

- Mouth closed

- Repetitive actions/movements

- Right Leg

- Unusual sounds

- Other -

- Other

- Turns head to one side, if yes which side?

- Incontinence – if so:

- Urine

- Faeces

## After
<table>
<thead>
<tr>
<th>Confusion</th>
<th>Tearful</th>
<th>Hyperactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression</td>
<td>Change in appetite</td>
<td>Twitching</td>
</tr>
<tr>
<td>Drowsy</td>
<td>Thirsty</td>
<td>Colour of skin</td>
</tr>
<tr>
<td>Headache</td>
<td>Other -</td>
<td>-</td>
</tr>
</tbody>
</table>

Have you requested a review of their epilepsy? If not document reasons.
# Appendix 2 - Bathing and showering risk assessment

<table>
<thead>
<tr>
<th>SEIZURES BATHING RISK ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be completed by nursing staff and then referred to OT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>Name of Assessor:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location of assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed date of review:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## Hazards: Please answer the following:

- Is this person newly diagnosed with epilepsy or had a first seizure? **YES/NO**
- Does this person have an established epilepsy diagnosis? **YES/NO**
- Does the person need support with bathing or showering? **YES/NO**
- Can they get in and out, sit up/stand and wash themselves unaided? **YES/NO**
- Is their sensitivity to temperature impaired? **YES/NO**
- Are they capable of summoning assistance if needed? **YES/NO**
- Is there a need for aids and adaptations? **YES/NO**
- Any medical problems or behaviours such as epilepsy /heart condition which pose a drowning risk? **YES/NO**

## Reducing the risk

If hazard identified describe possible risks

Reducing the risk consider:

- Can the activity be avoided?
- Can the activity be substituted?
- What action can we take to reduce risk

Plan to reduce risks
Appendix 3: To be completed by OT on receipt of appendix two.

<table>
<thead>
<tr>
<th>OCCUPATIONAL THERAPY</th>
<th>BATH / SHOWER ASSESSMENT TOOL FOR SEIZURES / EPILEPSY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Address:</td>
<td>RIO Number:</td>
</tr>
</tbody>
</table>

**CONSENT**

- Has the reason for the bathing assessment been explained?  Yes / No
- Has the client given informed consent?  Yes / No
- Is a best interest decision necessary?  Yes / No

**HEALTH**

- Diagnoses:
- Medication:
- Reported side effects:

- Epilepsy or first seizure?  Yes / No
  
  *If yes, state type, frequency, pattern, warnings, past injuries sustained:*

- Sensory Impairment:  Yes / No
  
  *If yes, state type, for example, visual impairment:*
### ENVIRONMENT

Ward/ Own home/Residential care/Supportive living etc.

Location of, access to and description of Bathroom and shower room

*For example, size, flooring, shower/ bath, location of bathing suite, hazards, clutter*

Aids used at time of assessment:

*For example, shower chair, bath seat, hoist, bath lift, grab rails*

If community – who does the patient live with and support available:

Do they have emergency procedures in case of seizure

*For example telecare or carer intervention*

### OCCUPATIONAL PERFORMANCE: BATHING/SHOWERING

Are they Independent: *Yes* / **No**

*If independent, please proceed to ‘Recommendations’ section.*

**If not independent and require assistance, please fill table below by ticking level of support required against area of difficulties*

<table>
<thead>
<tr>
<th>Gross Motor Skills</th>
<th>Fine Motor Skills</th>
<th>Sensory Skills</th>
<th>Cognitive and Perception Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. mobility, transfers, muscular endurance.</td>
<td>e.g. manipulating objects, brushing teeth</td>
<td>e.g. vision, tactile, proprioception</td>
<td>e.g. logical sequencing, concentration and depth awareness</td>
</tr>
</tbody>
</table>

Requires minimal support
Requires moderate support
Dependent – Please specify:

- Assistive Aids (A)
- Person Required (P)
### COMMUNICATION

*For example, how does the client communicate, does the client understand what is being asked.*

### RISKS IDENTIFIED AT TIME OF ASSESSMENT

### RECOMMENDATIONS

*Such as, skills teaching, adaptations, advice on using equipment, compensation techniques, alternative strategies.*

<table>
<thead>
<tr>
<th>Occupational Therapist:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cc:</th>
<th>Client</th>
<th>Client’s notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td></td>
<td>Primary Nurse</td>
</tr>
</tbody>
</table>
Appendix 4

Infection Prevention and Control and Bath Aids

BATH MATS
These must be only used (if required) by the specific patient (who will be encouraged to clean them after use, or assisted by the nursing staff if unable to do this).

- In line with the latest guidance, patients with epilepsy must have a bath mat in place when bathing
- These should be single-patient use
- Bath mats are hard to clean as they have lots of nooks and crannies
- After each use, please ensure that patients are supported to clean the mats with detergent and hot water, or this is carried out by the nursing staff if patients are unable to do this.
- After cleaning the bath mat must be dried – using disposable paper towels or a clean towel
- The bath mat must be stored dry
- Regularly inspect the bath mat and if any mould develops please dispose and replace

General Infection Control Advice

Please ensure staff wear appropriate personal protective equipment when cleaning mats (apron as a minimum, and gloves if there is visible soiling)

As part of ward refurbishment please consider replacing the bath with an ‘anti-slip’ bath.
Appendix 5

Audit Standards for Epilepsy Guidelines

<table>
<thead>
<tr>
<th>Is the Epilepsy managed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Primary Care</td>
</tr>
<tr>
<td>- Secondary Care</td>
</tr>
<tr>
<td>- Neurology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there evidence in the case-notes of………</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
<th>Rationale Recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Joint decision making between service user/carer and clinicians?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b The decision to initiate drug treatment being made in consultation with the service user/carer?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1c When a service user/carer decided not to commence on AED therapy, that this decision is recorded</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a Is there a care plan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b The service user/carer being aware of the care plan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2c The service user being involved in developing the care plan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2d The carer involved?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2e The service user/carer having been offered a copy of the care plan?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2f Agreement between service users/carers and clinicians regarding content of care plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2g The care plan having been shared with primary care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3a The recording of whether the service user has the capacity to make decisions around epilepsy treatment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3b If not, has the best interest&quot; principle been applied?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4a</strong></td>
<td>A <strong>review</strong> of epilepsy within the past year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4b</strong></td>
<td>Seizure frequency in the last year is documented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4c</strong></td>
<td>The service user having access to written and visual information counselling services information about voluntary organisations epilepsy specialist nurses timely and appropriate investigations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5a</strong></td>
<td>A <strong>risk assessment</strong> having been completed?</td>
</tr>
<tr>
<td><strong>5b</strong></td>
<td>The risk assessment having been shared?</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6a</strong></td>
<td>Of a protocol/guidance for use of <strong>rescue medication</strong> <em>(rectal diazepam/buccal midazolam?)</em></td>
</tr>
<tr>
<td><strong>6b</strong></td>
<td>Of the rescue medication protocol/guidelines having been shared?</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7</strong></td>
<td>The service user/carer having a <strong>contact number</strong> for</td>
</tr>
<tr>
<td><strong>8</strong></td>
<td>A <strong>risk management</strong> plan?</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9</strong></td>
<td>That <strong>psychological</strong> issues have been discussed, (if applicable)?</td>
</tr>
</tbody>
</table>
Appendix 6

Annual Risk Acknowledgement Form
VALPROATE HAS RISKS IN PREGNANCY

If you use valproate while you are pregnant, your child has significant risk of serious harm. This form confirms that you or your carer/parent/responsible person understands the risks of using valproate.

Effective contraception is essential while taking valproate. Neither condoms nor oral contraceptives alone are sufficient. Long-term contraceptives are strongly recommended such as a coil (copper intrauterine device [IUD] or levonorgestrel intrauterine system) and contraceptive implant (progestogen-only implant), or sterilisation.

Contraceptive currently used: .................................................................

Name of valproate user: .................................................................

Name of responsible person (if applicable): .................................................................

Signature: ................................................................. Date: .................................................................
**Part A. To be completed and signed by the valproate user and/or carer/parent or responsible person**

I have discussed the following with my specialist and I understand:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why I need valproate rather than another medicine</td>
<td>☐</td>
</tr>
<tr>
<td>That I should visit a specialist regularly (at least once a year) to</td>
<td>☐</td>
</tr>
<tr>
<td>review whether valproate remains the best option for me</td>
<td></td>
</tr>
<tr>
<td>The risks in children whose mothers took valproate during pregnancy</td>
<td>☐</td>
</tr>
<tr>
<td>are:</td>
<td></td>
</tr>
<tr>
<td>- 1 out of 10 children will have physical birth defects</td>
<td>☐</td>
</tr>
<tr>
<td>- 3 to 4 out of 10 children will have early developmental problems</td>
<td>☐</td>
</tr>
<tr>
<td>that can lead to significant learning disabilities</td>
<td></td>
</tr>
<tr>
<td>That I have had a pregnancy test (if advised by my doctor/specialist)</td>
<td>☐</td>
</tr>
<tr>
<td>Why I must use effective contraception, without stopping or</td>
<td>☐</td>
</tr>
<tr>
<td>interruption, at all times while taking valproate</td>
<td></td>
</tr>
<tr>
<td>The options for effective long-term contraception (or a consultation</td>
<td>☐</td>
</tr>
<tr>
<td>has been planned with a professional who can give me advice</td>
<td></td>
</tr>
<tr>
<td>The need to consult my specialist or GP as soon as I start thinking</td>
<td>☐</td>
</tr>
<tr>
<td>about becoming pregnant. This is to make sure I have time to</td>
<td></td>
</tr>
<tr>
<td>switch to another treatment before I come off contraception</td>
<td></td>
</tr>
<tr>
<td>That I should request an urgent GP appointment if I think I</td>
<td>☐</td>
</tr>
<tr>
<td>am pregnant</td>
<td></td>
</tr>
<tr>
<td>That I have a copy of the Patient Guide and know where to find</td>
<td>☐</td>
</tr>
<tr>
<td>more information</td>
<td></td>
</tr>
<tr>
<td>In case of pregnancy, I confirm that:</td>
<td>☐</td>
</tr>
<tr>
<td>I have considered and discussed options for switching treatment</td>
<td></td>
</tr>
<tr>
<td>I am fully aware of the risks and have the opportunity to have</td>
<td></td>
</tr>
<tr>
<td>counselling about the risks</td>
<td></td>
</tr>
</tbody>
</table>
Annual Risk Acknowledgement Form

VALPROATE HAS RISKS IN PREGNANCY

If a woman uses valproate while she is pregnant, her child may be harmed. This form confirms that you have explained the risks of using valproate.

Name of valproate user: ……………………………………………………………………………

Name of responsible person (if applicable): …………………………………………………

Name, role, and signature of specialist:

………………………………………………………………………………………………………………

Name of valproate user’s GP: ………………………………………………………………………

Date: …………………………………………………………………………………………………

The specialist must provide this form to girls and women of childbearing potential treated with valproate (Epilim, Depakote, Convulex, Episenta, Epival, Kentlim, Orlept, Syonell, Valpal) - or to their “responsible person”: a parent/legal guardian or person capable of giving consent on behalf of patients who are minors or without the capacity to make an informed decision or person acknowledging that the treatment is in the best interests of the patient.

A copy of the completed and signed form shall be kept/recorded by the specialist. The prescriber is advised to save an electronic version in the patient dossier. Copies of the completed and signed form should be given to the patient and also sent to their GP.

This form expires 12 months from this date. A new form should be completed at each annual review

More information can also be found online at www.medicines.org.uk by entering “valproate” in the search box and then clicking on “Risk Materials” next to any of the medicines that appear
I confirm that the above-named patient needs valproate because:

- her condition does not respond adequately to other treatments, or  
- she does not tolerate other treatments

I confirm that I have discussed the following information with the person named above:

<table>
<thead>
<tr>
<th>Valproate must not be used during pregnancy (except in rare situations in epilepsy for patients who are resistant or intolerant to other treatments)</th>
<th>Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall risks in children exposed to valproate during pregnancy are:</td>
<td></td>
</tr>
<tr>
<td>• an approximately 10% chance of birth defects</td>
<td></td>
</tr>
<tr>
<td>• a 30 to 40% chance of a wide range of early developmental problems that can lead to learning disabilities.</td>
<td>Discussed</td>
</tr>
<tr>
<td>The conditions of the pregnancy prevention programme must be fulfilled</td>
<td>Discussed</td>
</tr>
<tr>
<td>The need for regular (at least annual) review of the need to continue Valproate treatment by a specialist</td>
<td>Discussed</td>
</tr>
<tr>
<td>The need for effective contraception, without interruption, throughout treatment with valproate</td>
<td>Discussed</td>
</tr>
<tr>
<td>The need to arrange an appointment with her specialist as soon as she is planning pregnancy to ensure timely discussion and switching to an alternative treatment before conception and before stopping contraception.</td>
<td>Discussed</td>
</tr>
<tr>
<td>The need to contact her GP immediately for an urgent review of her treatment in case of suspected or inadvertent pregnancy.</td>
<td>Discussed</td>
</tr>
<tr>
<td>The patient or caregiver/legal representative has a copy of the patient guide</td>
<td>Discussed</td>
</tr>
<tr>
<td>The need for a negative serum pregnancy test result at start and if needed thereafter</td>
<td>Discussed</td>
</tr>
</tbody>
</table>

In case of pregnancy, I confirm that:

- We have discussed options for switching treatment  
- She is fully aware of the risks of pregnancy, has opportunity for counselling about risks

I have given the patient or caregiver/legal representative a copy of the patient guide, and informed her that information can also be found online at www.medicines.org.uk. Enter “valproate” in the search box and then click on “Risk Materials” next to any of the medicines that appear. In case of pregnancy, I confirm that:

- options for switching treatment in this pregnant patient have been considered  
- the patient is fully aware of the risks associated with the pregnancy and has access to counselling
Appendix 7

Junior Doctor Seizure Checklist

<table>
<thead>
<tr>
<th>Name of Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rio/NHS No</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Psychiatric Diagnosis ICD10</td>
</tr>
<tr>
<td>Medical Diagnosis/Epilepsy</td>
</tr>
<tr>
<td>Medication List</td>
</tr>
<tr>
<td>Inpatient/Community</td>
</tr>
<tr>
<td>GP details</td>
</tr>
<tr>
<td>Epilepsy Care Plan</td>
</tr>
<tr>
<td>Management of Status Epilepticus</td>
</tr>
<tr>
<td>Valproate Annual Risk Acknowledgement Form</td>
</tr>
</tbody>
</table>