Status Epilepticus and Prolonged Seizures
Guideline for Management in Adults

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Approving Committee Medicines Management Group
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Key Points

- Benzodiazepines are the first line treatment for prolonged convulsive seizures and status epilepticus. IV lorazepam, IM midazolam or buccal midazolam are the preferred options. IV diazepam may be used in patients with IV access if lorazepam is not available.

- Levetiracetam is the second line treatment of choice in women of childbearing age. Sodium valproate may be used in all other cases. Phenytoin may also be used, but may carry a higher risk of complications, and special precautions need to be observed (appendix1).

- Failure to take medication as prescribed is the commonest reason for patients with epilepsy developing status epilepticus. Therefore, choice of emergency medication does not vary depending on patients’ long term AED treatment.

- Patients who continue to experience seizure in spite of second line therapy, and those who fail to regain consciousness should be admitted to ICU

Remember: Non Epileptic Attack Disorder (NEAD) is at least as common as epilepsy in patients presenting with apparent status epilepticus

The clinical management is summarised in the flowing diagrams: (click to navigate)

5.5 Algorithm for management of prolonged convulsive seizures and status epilepticus in adults

5.6 Suggested algorithm for management of refractory convulsive status epilepticus in adults
1. **Overview (What is this guideline about?)**

These guidelines relate to the management of prolonged seizures and status epilepticus in patients aged 16 and over. They reflect the current evidence base in the management of this condition. While many of the interventions can only be delivered in a secondary care setting, initial management options are provided that would be appropriate in the community setting.

If you have any concerns about the content of this document please contact the author or advise the Document Control Administrator.

2. **Scope (Where will this document be used?)**

All staff who manage patients who may experience epileptic seizures, in particular those working in emergency department, neurosciences and critical care unit.

**Associated Documents**
- Valproate use by women and girls of childbearing age
  
  https://www.gov.uk/guidance/valproate-use-by-women-and-girls

3. **Background (Why is this document important?)**

Convulsive status epilepticus is a medical emergency requiring rapid diagnosis and management to prevent both immediate complications and long-term sequelae.

4. **What is new in this version?**

Doses of levetiracetam and sodium valproate have been updated. These doses are greater than have been used previously and reflect latest trial evidence.

Venous blood gases added to emergency bloods to be checked at presentation.

5. **Guideline**

5.1 **Initial management**

All patients experiencing generalised tonic clonic seizures (GTCS) should have ABC management and high flow oxygen. GTCS that last longer than 5 minutes, or two minutes longer than habitual seizures in patients known to have epilepsy, have a low chance of terminating spontaneously. Therefore, emergency intravenous antiepileptic medication should be administered to all patients who experience convulsive seizures lasting 5 minutes or longer. Benzodiazepines (lorazepam, midazolam and diazepam) are first line treatment. Second line treatments include sodium valproate, levetiracetam and phenytoin. Patients whose seizures continue in spite of second line treatment should be admitted to the intensive care unit for intravenous general anaesthesia and mechanical ventilation.
5.2 First line treatment:--

Benzodiazepines are first line treatment, and should be administered if seizure is ongoing at 5 minutes.

- For patients with intravenous access, IV Lorazepam 0.1 mg/kg (usually 4 mg bolus) is the drug of first choice. IV diazepam emulsion (5-10mg) may be used if lorazepam is not available\(^1,2\)

- For patients who do not have intravenous access, **BUCCAL / IM** Midazolam 10mg is the treatment of choice\(^2\). Buccal midazolam 10mg in 1ml or 10 mg in 2ml is commonly used in the community setting, and may be used if IV access is not available. Intramuscular midazolam 10mg was shown to be non inferior to lorazepam in one trial, and could be used in patients where there are no contraindications to IM injections (eg: anticoagulation). Midazolam 10mg in 2ml solution should be used for IM injection

- Rectal diazepam 10 mg should be reserved for patients with refractory epilepsy, who have rectal diazepam prescribed as their usual rescue therapy in the community\(^1\).

- A second dose may be administered if seizure is not terminated 5 minutes after administration of the first dose.

5.3 Second line treatment:--

If seizure is not terminated 20 minutes after onset, in spite of administration of 2 doses of benzodiazepines, second line treatment should be administered. There is no clear evidence of difference in efficacy between levetiracetam and valproate. In female patients of child-bearing age, levetiracetam is first choice second line treatment. In other cases, valproate or levetiracetam may be used. Phenytoin is likely to be associated with greater risk of side effects, and is to be regarded as third line treatment after levetiracetam/valproate.

**Levetiracetam**

- IV Levetiracetam 60mg /kg (up to a maximum of 4500mg, patients weighing 75kg and over) infused over 10 minutes (see table 1), followed by maintenance dose. As levetiracetam is primarily renally cleared, a maintenance dose reduction is required in patients with impaired renal function. (see table 2)

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Dose</th>
<th>Volume of 100mg/mL vials</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24kg</td>
<td>1200mg</td>
<td>12mL</td>
</tr>
<tr>
<td>25-29kg</td>
<td>1500mg</td>
<td>15mL</td>
</tr>
<tr>
<td>30-34kg</td>
<td>1800mg</td>
<td>18mL</td>
</tr>
<tr>
<td>35-39kg</td>
<td>2100mg</td>
<td>21mL</td>
</tr>
</tbody>
</table>
- Dilute the required dose with at least 100mL sodium chloride 0.9% or glucose 5%

**Table 2 – Levetiracetam maintenance dose**

<table>
<thead>
<tr>
<th>eGFR</th>
<th>Maintenance dose/interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80ml/min</td>
<td>1500mg BD started 12 hours after loading dose</td>
</tr>
<tr>
<td>50-79ml/min</td>
<td>1000mg BD started 12 hours after loading dose</td>
</tr>
<tr>
<td>30-49ml/min</td>
<td>750mg BD started 24 hours after loading dose</td>
</tr>
<tr>
<td>&lt;30ml/min, PD, HD patients (see below if HD)</td>
<td>500mg BD started 36 hours after loading dose</td>
</tr>
</tbody>
</table>

**Levetiracetam in haemodialysis patients**

- Administer 250mg levetiracetam after each HD if the next dose is not immediately due
- If HD occurs within 36 hours of the initial loading dose, begin the maintenance dose immediately after dialysis

**Sodium Valproate**

- IV Sodium valproate 40 mg/kg (up to maximum 3000 mg, patients weighing 75kg and over) infused over 10 minutes (see table 3), followed by maintenance dose 600mg TDS started 8 hours after the loading dose. **Valproate should not be used in women in the child-bearing age group (8 to 55 years), unless alternatives are ineffective**\(^1,2\). Consult the [MHRA guidance](https://www.mhra.gov.uk) before administering to this group of patients. Use with caution in patients with liver disease, check LFTs and serum ammonia in 24 hours.

**Table 3 – Sodium Valproate Loading dose**

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24kg</td>
<td>800mg</td>
</tr>
</tbody>
</table>
Dilute with sodium chloride 0.9% or glucose 5%. There is no recommended concentration for dilution but a minimum volume of 50mL is advised.

**Phenytoin**

- IV Phenytoin 20mg/kg (up to a maximum of 2g), infused at a rate of 25-50mg/min (max 50mg/min) for “typical” rate and 10-25mg/min for elderly/those with history of cardiac disease followed by maintenance dose of 100mg TDS started 24 hours after the loading dose. Serum concentration should be measured 2 hours after initial loading dose and then rechecked every 5-7 days. Levels should be checked sooner if there are concerns of toxicity or poor response. Phenytoin should be avoided in the elderly because of increased risk of cardiovascular complications, as well as in those at risk of drug interactions (patients on chemotherapy, anticoagulation with warfarin)\(^1\),\(^2\) Please refer to appendices for safe administration of phenytoin.

**Table 4 – Phenytoin Loading dose**

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Dose (halve this dose in elderly or cardiac disease)</th>
<th>Volume of 250mg/5mL vials</th>
<th>Minimum dilution volume of sodium chloride 0.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-29kg</td>
<td>1000mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-34kg</td>
<td>1200mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-39kg</td>
<td>1400mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-44kg</td>
<td>1600mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-49kg</td>
<td>1800mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-54kg</td>
<td>2000mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-59kg</td>
<td>2200mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-64kg</td>
<td>2400mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-69kg</td>
<td>2600mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70-74kg</td>
<td>2800mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75kg and over</td>
<td>3000mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.4 Treatment of refractory status epilepticus

Patients whose seizures continue after administration of second line treatment (usually 30-60 minutes after onset) have Refractory Status Epilepticus (RSE). Management of RSE requires general anaesthesia and admission to ICU. All such patients should also be discussed with the on-call neurologist.

- Midazolam, propofol and thiopentone may be used to induce general anaesthesia.
- Opioids (fentanyl, alfentanil, remifentanil) should be avoided, as they are generally pro-convulsant.
- EEG monitoring, either continuously or by repeated recordings, should be performed to confirm that seizure activity has been suppressed and ensure no breakthrough seizures occur.
- Burst suppression is the commonly used EEG target of anaesthetic drug treatment, and should be maintained for a period of 24-48 hours.
- SE that recurs on withdrawal of anaesthesia represents super refractory SE (SRSE). Additional treatment with antiepileptic drugs not mentioned above, ketamine, inhalational anaesthetics, hypothermia, magnesium, pyridoxine, immunotherapy, plasma exchange, ketogenic diet, emergency neurosurgery, vagal nerve stimulation and deep brain stimulation may be considered in selected cases by the neurology/epilepsy team.

Algorithms for the management of prolonged seizures and status epilepticus, as well as for management of refractory status epilepticus on ICU are shown below.

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Midazolam</th>
<th>Propofol</th>
<th>Thiopentone</th>
<th>Total Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>55-59kg</td>
<td>1100mg</td>
<td>22mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>60-64kg</td>
<td>1200mg</td>
<td>24mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>65-69kg</td>
<td>1300mg</td>
<td>26mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>70-74kg</td>
<td>1400mg</td>
<td>28mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>75-79kg</td>
<td>1500mg</td>
<td>30mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>80-84kg</td>
<td>1600mg</td>
<td>32mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>85-89kg</td>
<td>1700mg</td>
<td>34mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>90-94kg</td>
<td>1800mg</td>
<td>36mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>95-99kg</td>
<td>1900mg</td>
<td>38mL</td>
<td>250mL</td>
<td></td>
</tr>
<tr>
<td>100kg or above</td>
<td>2000mg</td>
<td>40mL</td>
<td>250mL</td>
<td></td>
</tr>
</tbody>
</table>
5.5 Algorithm for management of prolonged convulsive seizures and status epilepticus in adults

Convulsive seizure activity >5 minutes

- Airway, Breathing, Circulation
- Start high flow O2
- IV access*, Urgent bloods*
- BM check, SpO2, ECG, VBG, BP

Psychogenic non-epileptic attack (Pseudoseizure)

- Observe
- Monitor SpO2, pulse, resp rate
- Avoid parenteral drugs
- Review previous records

Seizure activity stops

Further assessment

- History from family/carers
- Neurological exam
- Review blood results
- If no previous h/o epilepsy, or abnormal exam
  - Urgent CT brain
- If febrile, start: Aciclovir 10 mg/kg IV tds
  - Ceftriaxone 2g IV BD
  - Urgent CT then LP

Further management

- Disposition will be dictated by recovery of consciousness over 10-30 min
- If GCS <10, need urgent ICU review for airway management
- Obtain urgent EEG to exclude non-convulsive SE
- If phenytoin used, send levels 2hrs post-loading
- Discuss with Neurology registrar on call re optimisation of AEDs

Urgent bloods

- FBC, U&E, LFTs, Ca, Mg, PO4, ESR, CRP, Coag. screen
- AED levels – patients on Sodium Valproate/Phenytoin / Carbamazepine/Leveriracetam
- Toxicology

IV Access – if this cannot be immediately obtained consider:

- Intramuscular / Buccal Midazolam 10mg

Consider and treat hypoglycaemia in all patients: hypoglycaemia QRG (click)

Epileptic seizure

Lorazepam 4 mg IV / Midazolam 10mg buccal/IM

Continuing seizure at 5 minutes

Repeat Lorazepam 4mg IV / Midazolam 10mg buccal/IM monitor for respiratory depression

Continuing seizure at 5 minutes

- IV levetiracetam 60 mg/kg over 10 min
- IV valproate 40 mg/kg over 10 min (not in child bearing age women)
- Request urgent ICU review

Seizure activity stops

Continuing seizure activity

REFRACTORY STATUS PROTOCOL

- If GA delayed, consider:
  - Further Lorazepam 4mg IV
  - Additional second line agent (eg: phenytoin)

Still doubt?

- Consider urgent EEG
5.6 Suggested algorithm for management of refractory convulsive status epilepticus in adults

Convulsive seizure activity for 40 – 60 minutes, not terminated by IV lorazepam x 2 and second line agent (eg: IV levetiracetam or valproate)

General Anaesthesia
- Induction with propofol, midazolam or thiopentone by a clinician with appropriate expertise. Avoid opioids where possible.
- Maintenance anaesthesia with continuous infusion of propofol and/or midazolam (high doses may be required). Avoid opioids.
- Intubate, ventilate, arterial line, central access
- Admit to ICU
- Observe for subtle convulsive activity
- If ongoing motor activity,
  - Thiopentone 3-5 mg/ kg IV bolus, and continuous IV infusion with processed EEG monitoring

Obtain urgent EEG to ensure electrographic seizures abolished and burst suppression achieved

Continuous EEG monitoring, or regular EEG recordings
- Correct any metabolic derangement
- Ensure on adequate antiepileptic medication
  - If on phenytoin, check level – consider further IV loading dose
- Neurology review re
  - Optimise pre-existing AEDs
  - Consider second line agents
  - Treatment of underlying cause

Daily Bloods
  - FBC, U&E, LFT, CRP, CK, Coagulation screen, Phenytoin levels
  - Consider daily EEG (if continuous monitoring not available)
  - Investigations for autoimmune encephalitis

Further assessment
- Further history
- Neurological exam
- Review blood results
- Urgent CT brain (all patients)
- If febrile  - Aciclovir 10 mg/kg IV tds
  - Ceftriaxone 2g IV BD
  - Urgent CT then LP

Maintain burst suppression with no breakthrough seizures (clinical or EEG) for 24 - 48 hours
6. Roles & responsibilities

This protocol applies across the site. For each Directorate:

6.1 Clinical Director
The Clinical Director has responsibility for holding clinicians to account for delivery of the protocol

6.2 Clinical Governance Lead
The Clinical Governance lead is responsible for dissemination of the protocol

6.3 Medical teams
Each member of the medical team involved in the management of this patient group is responsible for adhering to the protocol

7. Monitoring document effectiveness

Audit of patients treated with emergency antiepileptic medication in ED, ICU and MAU to ascertain adherence to policy

8. Abbreviations and definitions

AED  anti-epileptic drug
NEAD non-epileptic attack disorder
SE  Status Epilepticus
RSE Refractory status epilepticus
SRSE Super refractory status epilepticus
GTCS grand tonic clonic seizure
PD  peritoneal dialysis
HD  haemodialysis
EEG  electroencephalogram

9. References


10. Appendices

Appendix 1

Administration of IV Phenytoin on ANU, neurosurgical and medical wards

Although IV phenytoin will usually be administered in an emergency setting in the emergency department, neurosciences HDU or ICU, it is anticipated that the administration of IV phenytoin will occasionally be necessary on the Acute Neurology Unit, other medical wards, or the neurosurgical wards.

Circumstances where this may occur include, but are not limited to:

a) Patients recovering from acute seizures or status epilepticus that may have been treated with benzodiazepines, but who are likely to have further seizures
b) Patients at increased risk of seizures and who are nil by mouth
c) Patients in status epilepticus awaiting transfer to ICU
d) Patients with refractory seizures, but in whom there are other medical reasons for not being suitable for transfer to ICU

In such cases the treating physician may prescribe IV phenytoin to be administered on the ward. In all cases where the diagnosis is not status epilepticus, as defined by the protocol, the following criteria should be met, to reduce the risk of adverse events:

Table 5 *Adapted from reference 5*

- Between 16 and 60 years of age
- No history of underlying cardiovascular problems
- No chronic or acute debilitating illness, emaciation, hyponatremia, peripheral vascular disease, hemodynamic instability, or sepsis
- Good intravenous access qualified by one of the following: size at least as large as antecubital fossa vein, catheter size 20 gauge or larger, pre-existing central venous catheter
- Pain assessment possible such that extravasation of phenytoin sodium may be recognized
Once the decision to administer IV phenytoin is made the following points regarding drug administration need to be considered:

Table 6

<table>
<thead>
<tr>
<th>Dose</th>
<th>15-20mg/kg IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>Max 50mg/min</td>
</tr>
<tr>
<td></td>
<td>Healthy adult – 25-50mg/min</td>
</tr>
<tr>
<td></td>
<td>Elderly/Possible cardiovascular disease – 10-25mg/min</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Continuous cardiac monitoring (rate, rhythm), blood pressure every 2 minutes</td>
</tr>
<tr>
<td></td>
<td>• If pulse &lt;55 SLOW infusion rate</td>
</tr>
<tr>
<td></td>
<td>• If pulse &lt;45 STOP infusion</td>
</tr>
<tr>
<td></td>
<td>• If pulse &lt;35 CALL doctor</td>
</tr>
<tr>
<td></td>
<td>• If systolic BP &lt; 110 SLOW infusion rate</td>
</tr>
<tr>
<td></td>
<td>• If systolic BP &lt; 100 STOP infusion</td>
</tr>
<tr>
<td></td>
<td>• If systolic BP &lt; 90 CALL Doctor</td>
</tr>
<tr>
<td></td>
<td>• If symptomatic with hypotension (clammy, lightheaded) CALL Doctor and commence IV Fluids (Plasmalyte 250ml)</td>
</tr>
<tr>
<td></td>
<td>• If patient becomes unresponsive CRASH call, STOP infusion</td>
</tr>
<tr>
<td>Infusion</td>
<td>Begin and complete preparation and infusion within 1 hour</td>
</tr>
<tr>
<td></td>
<td>Infuse through free-flowing IV of 0.9% sodium chloride</td>
</tr>
<tr>
<td></td>
<td>Use 5 micrometre in-line particulate filter</td>
</tr>
</tbody>
</table>

The above monitoring parameters may be altered by the attending physician in individual cases such as patients whose initial BP is very high (known hypertensives) or physiologically low (healthy young adults)
Appendix 2

Algorithm for IV phenytoin administration

Once the decision is made to administer IV phenytoin the following algorithm can be followed, particular attention must be paid to monitoring for infusion site reactions and cardiovascular instability:

IV Phenytoin

Criteria for administration met (see Table 1)

Give IV phenytoin (see Table 2)

Monitor injection site

Monitor cardiac rate rhythm and blood pressure

Extravasation?

Burning?

Bradycardia?

Hypotension?

Stop infusion

Slow infusion

Slow infusion, monitor

Restore volume, slow infusion, monitor

Persistent

Persistent

Persistent

Stop infusion, elevate limb, apply heat

Stop infusion

Stop infusion

Stop infusion
### 11. Document Control Information

All sections must be completed by the author prior to submission for approval

<table>
<thead>
<tr>
<th>Lead Author:</th>
<th>Rajiv Mohanraj, Consultant Neurologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead author contact details:</td>
<td>0161 206 4626 <a href="mailto:Rajiv.Mohanraj@srft.nhs.uk">Rajiv.Mohanraj@srft.nhs.uk</a></td>
</tr>
</tbody>
</table>

#### Consultation

List the persons or groups who have contributed to this guideline. (please state which Care Organisation)

<table>
<thead>
<tr>
<th>Name of person or group</th>
<th>Role / Department / Committee (Care Org)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jude Allen</td>
<td>Lead Renal Pharmacist, Pharmacy, SRFT</td>
<td>14/02/2020</td>
</tr>
<tr>
<td>Emma Boxall</td>
<td>Critical Care Pharmacist, Pharmacy, SRFT</td>
<td>14/02/2020</td>
</tr>
<tr>
<td>Jonathan Greenbaum</td>
<td>Consultant, SRFT</td>
<td>09/03/2020</td>
</tr>
</tbody>
</table>

#### Endorsement

List the persons or groups who have seen given their support to this guideline. (please state which Care Organisation)

<table>
<thead>
<tr>
<th>Name of person or group</th>
<th>Role / Department / Committee (Care Org)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janet Hegarty</td>
<td>Clinical Effectiveness Committee</td>
<td>February 2020</td>
</tr>
<tr>
<td>Richard Cooper</td>
<td>Medicines Management Group</td>
<td>16/03/2020</td>
</tr>
</tbody>
</table>

#### Keywords / phrases:

status epilepticus, seizures, convulsion, generalised tonic clonic seizure, pseudo status

#### Communication plan:

State below how the practice in this document will be rolled out across the organisation and embedded in practice

New guidelines will be published on intranet
Email communication will be sent to the Manchester Centre for Clinical Neurosciences for circulation

#### Document review arrangements:

This document will be reviewed by the author, or a nominated person, at least once every three years or earlier should a change in legislation, best practice or other change in circumstance dictate.

### Guideline Approval:

Name of Approving Committee: Medicines Management Group

Chairperson: Dr Richard Cooper

Approval date: 16/03/2020

Formal Committee decision (x) Chairperson's approval (x)
12. Equality Impact Assessment (EqIA) screening tool

Legislation requires that our documents consider the potential to affect groups differently, and eliminate or minimise this where possible. This process helps to reduce health inequalities by identifying where steps can be taken to ensure the same access, experience and outcomes are achieved across all groups of people. This may require you to do things differently for some groups to reduce any potential differences.

1a) Have you undertaken any consultation/involvement with service users, staff or other groups in relation to this document?  
Yes/No  
Please state:

1b) Have any amendments been made as a result?  
Yes/No  
Please Comment:

2) Does this guideline have the potential to affect any of the groups below differently or negatively? This may be linked to access, how the process/procedure is experienced, and/or intended outcomes. Prompts for consideration are provided, but are not an exhaustive list.

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Reasons for decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)</td>
<td>x</td>
<td></td>
<td></td>
<td>Additional risks</td>
</tr>
<tr>
<td>Sex (e.g. is gender neutral language used in the way the guideline or information leaflet is written?)</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)</td>
<td></td>
<td>x</td>
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</tr>
<tr>
<td>Religion &amp; Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered.)</td>
<td></td>
<td>x</td>
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<tr>
<td>Sexual orientation (e.g. is inclusive language used? Are there different access/prevalence rates?)</td>
<td></td>
<td>x</td>
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<tr>
<td>Pregnancy &amp; Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding women?)</td>
<td>x</td>
<td></td>
<td></td>
<td>Different procedure, referred to in section 3</td>
</tr>
<tr>
<td>Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)</td>
<td>x</td>
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<tr>
<td>Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)</td>
<td>x</td>
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<tr>
<td>Human Rights (e.g. does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)</td>
<td>x</td>
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<tr>
<td>Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)</td>
<td>x</td>
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<tr>
<td>Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)</td>
<td>x</td>
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<tr>
<td>Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas)</td>
<td>x</td>
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</tr>
</tbody>
</table>
suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.

| X | Epilepsy is a disability under the Equality Act 2010 |

Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)

3) Where you have identified that there are potential differences, what steps have you taken to mitigate these?
Phenytoin should be avoided in the older patients because of increased risk of cardiovascular complications.

Procedure would be slightly different in pregnant patients. Levetiracetam would be offered first as it is the lowest risk to unborn child. Sodium valproate is contraindicated in pregnant patients as it can cause birth defects so typically would be avoided.

4) Where you have identified adjustments would need to be made for those with disabilities, what action has been taken?
As stated in section 2 of the policy, the guidelines are for all staff who manage patients who may experience epileptic seizures, in particular those working in emergency department, neurosciences and critical care unit. Protocol for all patient groups is included in the guidelines.

The procedure would not be any different for patients with learning difficulties, but carers would be included in communication with the patients.

5) Where the policy, procedure, guidelines, patient information leaflet or project impacts on patients how have you ensured that you have met the Accessible Information Standard – please state below:
Carers would be involved in all communication. Guidelines would be available to staff in different formats such as large print.

EDI Team/Champion only: does the above ensure compliance with Accessible Information Standard
- Yes

Will this guideline require a full impact assessment? No
Please state your rationale for the decision: Impact has been mitigated as described above

(a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - Please contact the Inclusion and Equality team for advice on equality@pat.nhs.uk)

Author: Type/sign: K.Harwood Date: 17/04/2020

Sign off from Equality Champion: Date: 08/04/2020