# NDIS LWB 5542 Epilepsy – Management Plan

- The person we support and staff can complete Section 1 and Section 2 prior to the Neurologist or doctor appointment
- Neurologist or Doctor to complete Sections 3, 4 and 5 at the Health Appointment.
- The Plan must be signed by the Health Professional and reviewed at least annually, or more often as determined by the Health Professional
- The remaining sections are to be completed after the appointment.

| **Personal Details** | | | |
|---|---|---|---|
| **Name:** | | | |
| **CIRTS ID:** | | | |
| **Date of Plan:** | | **Review Date:** | |

| **Section 1: Safeguarding Requirements –** completed by staff and the person we support | | |
|---|---|---|
| The following safeguarding options are available for people receiving support with Epilepsy. | | |
| **Product Type** | **Risk Management Options** | |
| **Shared and Supported Living** | ***Option 2 or 3*** *below must be selected* | |
| **Lifestyle Supports** | ***Option 1, 2 or 3*** *below must be selected* | |
| **Agreed Risk Management Strategy** | | **Tick** |
| **1** | The person chooses to self-manage their Epilepsy and agrees to LWB following general emergency response - only if required *(Only for people in Lifestyle Supports)* | ☐ |
| **2** | The person has provided a current Epilepsy Management Plan and it is attached to Section 1 of this document | ☐ |
| **3** | The person will complete this NDIS LWB 5542 Epilepsy Management Plan with staff and a doctor | ☐ |

## Description of Seizures

Describe all seizure types the person experiences, including movement of limbs, noises made. The usual (most common) type of seizure is categorised as Type A and further seizures will be Type B and Type C. Where there are more, contact the DSSC to have more rows added to the form. Refer to completed NDIS LWB 5542a Seizure Activity - Recording Chart for guidance on timeframes and seizure types.

In “Other Observations” include details such as whether the person does not respond, their face changes colour – including what colour, whether their speech is slurred, whether they

make other sounds, whether they fall, bite their tongue, salivate, is incontinent, moves involuntarily, experiences an unusual breathing pattern or has seizures while sleeping.

| **Section 2: Seizure Types** - completed by staff and the person we support | | | |
|---|---|---|---|
| **Usual Seizure -Type A- Description:** | | | |
| **Length of seizure:** | | | |
| **How often seizures occur:** | | | |
| **Known causes / triggers:** | | | |
| **Typical signs after a seizure stops:** | | | |
| **Usual recovery pattern:** | | | |
| **Other observations:** | | | |
| **Seizure Type B - Description:** | | **N/A** | ☐ |
| **Length of seizure:** | | | |
| **How often seizures occur:** | | | |
| **Known causes / triggers:** | | | |
| **Typical signs after a seizure stops:** | | | |
| **Usual recovery pattern:** | | | |
| **Other observations:** | | | |
| **Seizure Type C – Description:** | | **N/A** | ☐ |
| **Length of seizure:** | | | |
| **How often seizures occur:** | | | |
| **Known causes / triggers:** | | | |
| **Typical signs after a seizure stops:** | | | |
| **Usual recovery pattern:** | | | |
| **Other observations:** | | | |

| **Section 3: Epilepsy Management Plan** – *to be completed by Health Professional* | | | |
|---|---|---|---|
| This Epilepsy Management Plan provides instructions on seizure management for staff. | **When seizure occurs while using a wheelchair** | **N/A** | ☐ |
| **1. When seizure starts:** | **1. When seizure starts:** | | |
| | | | |
| **2. While seizure continues:** | **2. While seizure continues:** | | |
| | | | |
| **3. After seizure stops:** | **3. After seizure stops:** | | |
| | | | |
| **PRN Medication (*required to be given as a result of a seizure*):** | | | |
| **PRN Medication** if required, must be listed on the person's Patient Medication Profile, COMPACT Medication Chart and Medication Record with specific instructions regarding administration and dose. | | | |
| **Midazolam Prescribed:** | ☐ No ☐ Yes ➔complete PRN Protocol – TEMPLATE<br>**Note:** Administration of Midazolam requires staff to successfully complete LWB HIDPA Training and Workplace Skills Assessment. | | |
| **When to call an ambulance: (dial 000)** | | | |
| | | | |
| **Emergency contact details: (for advice or assisting during or following the seizure)** | | | |
| | | | |

| **Section 4. Risk and Safety factors***: to be completed by Health Professional*<br>*Where not applicable, the Health Professional should indicate N/A* | |
|---|---|
| **Risk / safety factor** | **Strategies to eliminate or control risk** |
| **Dentures** (if applicable) | |

| | |
|---|---|
| **Person uses a Wheelchair** | |
| **Recommended level of supervision when bathing or showering** | |
| **Recommended water temperature for bathing / showering (if not 40°c)** | |
| **Recommended level of supervision when swimming –**<br>**Examples of swimming supervision:**<br>▪ Supervision from pool edge/shore<br>▪ 1:1 direct support in water<br>▪ 1 staff in pool/water, 1 staff on pool edge/shore *(the person will need 2:1 funding for this to occur)* | |
| **Floatation Device required?** | ☐ No ☐ Yes ➔Details: |
| **Recommended level of supervision while sleeping?**<br>e.g. Nil, check hourly, 4 hourly etc. | |
| **Seizure Mat recommended?** | ☐ No ☐ Yes ➔Details: |
| **Other seizure monitoring device recommended e.g. camera/audio?** | ☐ No ☐ Yes ➔Details: |
| **Strategies for Community Access support** | |
| **Protective equipment required e.g. Helmet** | |
| **Indications this plan should be reviewed immediately:** | |

| **Section 5: Current Medication (include all medications):** *to be completed by Health Professional* | |
|---|---|
| Copy of **Patient Medication Profile**, or **Medication Record** attached to this plan (*Tick when attached*) | ☐ Yes |

| Medical Professionals involved in the development of this plan | | | |
|---|---|---|---|
| **Neurologist** | | | |
| **Name:** | | **Contact Number:** | |
| **Address:** | | | |
| **Signature:** | | **Date:** | |
| **General Practitioner (GP)** | | | |
| **Name:** | | **Contact Number:** | |
| **Address:** | | | |
| **Signature:** | | **Date:** | |

| Section 6: LWB Staff involved in the development of this plan | | | |
|---|---|---|---|
| **Role:** | **Name** | **Signature:** | **Date:** |
| | | | |
| | | | |

| Section 7: Sharing information: | | | |
|---|---|---|---|
| *To assist people to support me in the management of my epilepsy, I consent to copies of this plan being provided to the other agencies and services indicated below. (Select as appropriate).* | | | |
| ☐ | School / Education Settings | ☐ | Community Access Program |
| ☐ | Recreation Program | ☐ | Employment Program |
| ☐ | Other (specify) | ☐ | Other (specify) |

| **Section 8: Approvals:** | | | |
|---|---|---|---|
| LWB have advised me of the safeguarding requirements under my funding and we have discussed and agree on the risk management strategies described this plan.<br>I consent to the support requirements as detailed in this Epilepsy Management Plan to be implemented in order to assist in the management of my epilepsy or receive general emergency response as required. | | | |
| **Name** | **Relationship to Person** | **Signature** | **Date** |
| | Person with epilepsy | | |
| | Authorised Decision Maker* | | |
| ** Must sign if person does not self-consent* | | | |

| **Section 9: LWB Staff Declaration (*All staff who work with this person to sign)*** | | | | | |
|---|---|---|---|---|---|
| I have read and understood this Epilepsy Management Plan and understand my responsibilities in providing support to the person. | | | | | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |
| Name | | Signature | | Date | |

| Review – *to be completed by Health Professional* |
|---|
| • A health professional must review this plan at least annually or as often as determined by the health professional. The health professional should also include signs that, if observed by staff, indicate an immediate review should take place. LWB Disability Support Staff must also monitor the person's health in the context of the STOP AND WATCH principles outlines in the NDIS LWB 5501 Health and Wellbeing - Procedure<br>• Plan Reviews can only be completed by the health professional who originally developed the plan or another health professional with equivalent qualifications. If the health professional has changed since the original plan was developed, they may wish to develop a new plan.<br>• If the current plan no longer meets the needs of the person, a new plan is required. |

| **Treating Health Professional Declaration** | | |
|---|---|---|
| I have today reviewed this plan and confirm that it remains appropriate to meeting the needs of the person. | | |
| Health Professional Name and Title | Health Professional Signature | Date |
| | | |
| | | |
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| | | |
| | | |

**Upload to CIRTS as follows:**
Plans & Assessments > New Plan > Plan name – [select from drop down] Epilepsy Management Plan > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD