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PATIENT EDUCATION

POLICY:
Patients, families, and/or significant others will be provided with adequate instructions and educational information related to their medical condition, testing procedures as well as test results and treatment options (when appropriate) to enhance their understanding, cooperation, and compliance.

PROCEDURE:
I. Telephone contact
   a. Patient calls for information will receive verbal assistance by appropriate personnel.
   b. Verbal instructions will be given to callers scheduling testing (physician, secretary, patient, or family) and such education will be documented in the appointment book.

II. Mail contact
   a. EEG, EP, EMG patients may be mailed instructions sheets if verbal instructions are not deemed effective.
   b. Polysomnography patients will be mailed informational packets containing pre-test instructions, sleep history forms and insurance coverage information prior to the scheduled test date.
   c. Appropriate brochures (as available) will be mailed to persons requesting information.

III. Personal contact
   a. On arrival in the department, the patient (and family if present) will be oriented to the department, informed of the approximate duration of the testing, and their questions will be answered. Educational pamphlets may be provided and appropriate videos presented.
   b. If testing has been ordered with sedation (and is to be performed on the nursing floor), the patient/family will be provided with information regarding dosage and side effects prior to administration of sedation by nursing staff.
   c. Patients/families will be informed that test results are forwarded to the referring physician for his review and discussion with the patient.
   d. All patients for overnight polysomnography to rule out obstructive sleep apnea will receive an initial introduction to PAP therapy by viewing the educational video and having a preliminary mask fit/acclimation period. If CPAP titration is performed (either on a scheduled, split-night, or emergency basis) additional information (including pamphlets and verbal) will be provided after testing is completed and at the time of equipment set up (by the medical equipment company).
   e. When appropriate, results of previous diagnostic testing may be reviewed with the patient/family during CPAP education to reinforce understanding of the medical condition and to improve compliance with therapy.
   f. Patient education will be provided in an individualized manner as part of the multidisciplinary approach to patient care.
g. An assessment of the patient/family/significant other ability to comprehend the material will help to determine the optimal methods and mode of education provided. This will include, but not be limited to, cultural and/or religious practices, emotional, physician, cognitive/learning, visual, hearing, language, or age related learning barriers. Desire, motivation, and readiness to learn will play key roles.

h. An evaluation of the patient’s understanding of the information will be made and reinforcement provided as necessary.

i. Documentation of patient education will be done on the appropriate multidisciplinary education sheet.
EPILEPSY MONITORING TECHNOLOGIST RESPONSIBILITIES

All techs on all shifts are responsible for:
1. Reviewing and clipping to within ½ hour of end of shift (There are times when this won’t be possible due to extenuating circumstances.)
2. Communicate what is happening to techs on the following shifts.
3. Maintaining integrity of recording.
4. Maintaining cleanliness of equipment, monitoring room and treatment room.
   - clean all glue and gauze off leads
   - don’t leave leads soaking for extended periods of time
   - change “chucks” in treatment room
5. Making sure parents are aware of need to push button for episodes in questions.
6. Making sure patient and families are following rules
   - wearing tracker
   - wearing helmet when out of bed
   - parents staying out of patient’s bed (parents may lay down with patient to get patient to sleep, but then need to get up and move to couch.)
7. Archiving
8. Defragging equipment
9. Disconnecting patients
10. Reporting problems with system to [name of department or person] and documenting in log.
11. Call [name of department or person] for any broken equipment.
12. Make sure patient are on camera.
13. Make sure treatment room is stocked with necessary supplies.

Hook ups will be done by 1st shift staff, during 1st/2nd shift overlap, or by on-call tech.

Video consent forms must be signed for all patients being hooked up. Verbal consent may be received when necessary via phone. Two people are required to sign form as witness for verbal consents. Verbal consents will normally only be acceptable for ICU patients as parents are required to stay with patients on EMU.

Tech hooking up patient should get information on what patient is here for and document activity in question on white board.

Tech needs to explain rules to patients and families.
- Tracker needs to be worn.
- Helmet needs to be worn when patient is out of bed.
- Parents need to stay out of patient’s bed.
- Family needs to try to not block cameras view.

Let parents and patients know they can go to the playroom. Other patients are not allowed in playroom when EMU patients are in playroom due to video monitoring.
**Reviewing and Clipping**

20 minutes of random wake and random sleep should be clipped for patients daily.

All patient push buttons should be clipped even if they are not seizures, unless they are an accidental push button. If tech doesn’t believe episode in question is a seizure, it should be clipped as “EVENT”.

All seizures should be clipped unless patient has excessive number of seizures. The epilepsy doctor will say when enough seizures have been clipped. Seizures should then be marked and counted for each shift.

Other things maybe clipped as necessary such as interictals, arousals, etc.

Patients who are unresponsive or in drug induced comas should have random samples clipped for full day containing 5 minutes every 3 hours.

**Archiving**

Patients can be archived as soon as they are disconnected. Techs can wait until there is enough data to fill disk before archiving patient.

Video can be deleted from Random Samples for coma patients before archiving.

After patient is archived, data needs to be left on system for 1 week to allow doctors to finish doing reports. Prior to removing any data from system, make sure that there is documentation of reports.

If data needs to remain on system for legal reasons, it should be moved to save full file bin. Once full files are archived, data can be cleared or deleted from system.

If data is needed for Epilepsy Conference, it should be moved to the Epilepsy Conference bin. Data can be cleared or deleted after patients are presented at Epilepsy Conference.

If a doctor requests data stay on system for other reasons, files can be moved to Doctor’s individual bin.

**Head Care**

Every third day, leads glued on skin areas (forehead, face, behind ears), should be moved to prevent breakdown.

Once a week all leads need to be moved.
Patients who can avoid scratching can have head wraps removed for extended periods if they can leave leads alone. This will prevent them from sweating as much or getting too itchy.

ICU patients who are not moving should not have head wrapped. Skin breakdown is increased in these patients and wrapping can cause pressure sores. ICU patients may need leads moved more often. If techs notice breakdown after first 3 days, leads should be moved every 2 days. Techs should record on white board when leads are moved and when they are due to be moved again.

Techs should try to avoid use of syringe on ICU patients when possible especially on forehead, due to increased risk of skin breakdown.

Avoid wrapping heads too tight as it can cause pressure sores.

Make sure tech sheet is appropriately filled out following disconnects. Be sure to mark or describe skin condition. If there are sores, make sure locations of sores are accurately stated on tech sheet.

Inform nurse of any breakdown or pressure sores so they can be appropriately treated.

**Database back-up and maintenance**

Third shift tech will be responsible for performing weekly database back up.
OPERATING ROOM ATTIRE

PURPOSE: Define proper clothing protocol for operating room (OR) environment

All:
To enter the Operating Room, you need to have badge access. If you do not, there is a speaker and camera above the badge reader that you can use. Request access and the Operating Room staff at the front desk will assist you.

Employee:
All OR staff must wear _______ [name of hospital, facility]-approved blue scrubs located in scrub machines in the locker rooms. Women’s locker rooms are on _______ [floor]. Men’s locker rooms are on _______ [floor]. Blue bouffant caps, surgical hats, shoe covers, and eyewear are located in locker rooms, in dressing-nook at entryway to the OR, and hallway connecting locker room tower to the OR.

All staff must have their ID badge visible at all times.

Staff may wear personal surgical caps as long as hair is covered.

Staff may opt to wear white “bunny suits” over his/her other clothing instead of blue scrubs. These are located in the dressing-nook at main entryway to OR. OR staff in training may also be instructed to wear bunny suits by his/her preceptor.

Contractors:
Contract workers are to comply with same regulations as Staff. See above.

Contract workers are responsible for keeping their ID badges valid. Badge renewal is required after one year. Scrub cards will be provided by the _______ [name of department, service].

Visitors:
Visitors must accompany a Staff member at all times. This person will guide visitors on OR Attire rules and Sterile Technique. Visitors will wear a visitor sticker with his/her name on it.

The items visitors will wear are located at the front entrance of the OR, in a nook just within the entry doorway. All visitors will wear white “bunny suits” over his/her clothing, blue bouffant or surgical hat, and blue shoe covers. Masks are located throughout the OR, outside of surgical suites and sterile core. House staff will show visitor where these are located, when and where they must be worn, and the appropriate way to wear this mask.
**Vendors:**
Vendors that visit the OR must fill out paperwork daily with the front desk. Vendors will receive a new ID sticker each day, which also has his/her photo on it. This sticker should be visible at all times.

Rules for attire of all vendors is identical to visitors (see above) except headwear. The nook containing bunny suits will have _______ [color; for example: red] bouffant hats for vendors to wear.
SURAL SENSORY NERVE CONDUCTION STUDY

**POLICY:** To describe the procedure for obtaining a sural sensory nerve conduction study.

**PROCEDURE:**

**Prep:** Wipe recording and stimulation sites with alcohol. Check limb temperature and warm if needed.

**Settings:**
- Sweep: 1 msec/div
- Sens/Gain: 10 µV/div
- Fillers: LLF - 20 Hz; HFF - 2 kHz

**Recording site:** The patient is positioned on their side with knee bent. Ground secured over dorsum of foot. A bar electrode is placed over the sural nerve with the active electrode just below the lateral malleolus with the reference distal to the recorder.

**Stimulation site:** Stimulation is directly over the sural nerve just lateral to the midline of the lower leg. Maximal response is obtained. Conduction velocity (CV) can be obtained by stimulating 2 sites along sural nerve.

**Comments:** Moving the ground between the stimulation and recording site is sometimes helpful. Averaging may be necessary to obtain acceptable waveform also may need to repositioning recording electrodes. Peak is taken for distal latency. The take-off of response must be used for latencies if CVs are done to measure the fastest fibers.

**Normal Values:**

<table>
<thead>
<tr>
<th>Latency (msec)</th>
<th>Amplitude (µV)</th>
<th>Conduction Velocity (m/sec)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;4.8</td>
<td>&gt;5</td>
<td>&gt;40</td>
</tr>
</tbody>
</table>