Guardian Light
quality care services

SEIZURE TRACKER • MONTHLY LOG

Guardian Light Quality Care Services • Monthly record of every seizure or suspected seizure, day and overnight shifts

Client name: _____ **Date of birth:** _____ **Site / room:** _____ **Month / year:** _____ **Tracking from (date):** _____ **to (date):** _____

Known seizure type / diagnosis (per care plan): _____ **Seizure / rescue medication (per care plan and MAR):** _____

#	Date	Shift (D / N)	Start time	Length (min)	Where / what was the client doing?	Warning signs / possible trigger (codes)	Seizure type (code) and what you saw	Action taken (codes)	Injury? Y / N	Back to usual (time)	Reported to	Staff initials
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

Shift: **D** Day shift **N** Overnight shift

Seizure type: **T** Tonic-clonic (stiffening, whole-body shaking) **A** Absence (blank stare) **F** Focal (one body part, twitching) **M** Myoclonic (sudden jerks) **U** Unwitnessed / found after

Warning / trigger: **SL** Poor sleep **SC** Screen / flashing light **MD** Missed or late dose **NM** New or changed medication **IL** Illness / fever **ST** Stress **OT** Other (write in)

Action taken: **1** Timed it **2** Turned onto side **3** Protected head / cleared area **4** Stayed with client **5** Rescue medication (per order) **6** Called 911 **7** Nurse / supervisor told **8** Family told

Record what you saw, not what you think it was. Do not put anything in the mouth or hold the person down. Follow the client's seizure care plan. Continue on page 2 if more rows are needed.

SEIZURE TRACKER • MONTHLY LOG (continued)

Client name: _____ **Month / year:** _____ **Site / room:** _____

#	Date	Shift (D / N)	Start time	Length (min)	Where / what was the client doing?	Warning signs / possible trigger (codes)	Seizure type (code) and what you saw	Action taken (codes)	Injury? Y / N	Back to usual (time)	Reported to	Staff initials
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												

CALL 911 RIGHT AWAY IF
• Seizure lasts 5 minutes or longer (or longer than the care plan says)
• Another seizure starts before the client recovers
• Trouble breathing, blue or gray lips or face
• Client is injured, or the seizure happened in water
• First seizure the client has ever had
• Client does not return to usual after the care plan time
Always tell the nurse or supervisor after any seizure, even a short one.

MONTHLY SUMMARY	
Total seizures this month	
Seizures by shift	Day: _____ Overnight: _____
Longest seizure (minutes)	
Seizure-free days	
Medication changes this month	Date / what:
Pattern noticed	☐ Night-time ☐ After med change ☐ Screen time ☐ Poor sleep ☐ None
Nurse / prescriber told	☐ No ☐ Yes – date: _____
Care plan reviewed	☐ No ☐ Yes – by: _____

Day staff signature: _____ **Night staff signature:** _____ **Date:** _____ **Received by (nurse):** _____ **Reviewed by supervisor / date:** _____