Guardian Light
quality care services

MONTHLY SLEEP TRACKER

Guardian Light Quality Care Services • Overnight summary, one line per night

Client name: _____ **Date of birth:** _____ **Site / room:** _____ **Month / year:** _____

Date	Time in bed	Time asleep	Final wake	Total sleep (hrs)	Wakings (no.)	Overall night S / M / U	Breathing ✓ or ✗	PRN given Y / N	Incident / fall Y / N	Notes	Staff initials
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3											
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Overall night: S Settled M Mostly settled U Unsettled **Breathing:** ✓ regular and unlaboured ✗ abnormal – act and report **Total sleep:** estimated from the night's checks

Use the Overnight Sleep Monitoring Record for detailed checks. Report any breathing concern, fall or distress immediately and note it in Notes.

Nights recorded: ____	Avg. sleep / night: ____ hrs	Unsettled nights: ____	Incidents / falls: ____	PRN given: ____	MONTH SUMMARY (complete at month end)

Completed by (name / signature): _____ **Reviewed by supervisor:** _____ **Date:** _____