Seizure Documentation Best Practices Guide

Introduction

Accurate documentation of seizure events is crucial for effective clinical follow-up, care plan adjustments, and ensuring compliance. This guide provides frontline staff with practical instructions on how to accurately and objectively record suspected seizure activity. Every documented observation contributes to the official record, which is used by clinical teams, surveyors, and family members to understand what occurred and how the care team responded.

What to Include

- **Date and Time:** When the event started and ended (estimate if unsure).
- **Resident Behavior:** What the resident was doing before, during, and after the event.
- **Responsiveness:** Did the resident respond to voice or touch?
- **Movements or Signs:** Describe unusual movements, staring spells, repetitive actions, or sudden changes.
- **Staff Response:** What was done to ensure safety or comfort?
- **Post-Event Status:** Note any confusion, fatigue, or other changes.
- **Notifications:** Document who was informed (e.g., charge nurse, family, provider) and when.

Tips for Effective Documentation

- **Be Objective:** Write what you saw, not assumptions or diagnoses.
- **Use Clear Language:** Avoid vague terms like “acted out” or “looked off.”
- **Include Duration:** Even brief events are essential to document.
- **Note Triggers:** Record possible triggers (e.g., medication change, infection, fatigue).
- **Link Observations:** If multiple staff observed the event, ensure notes are consistent.

Sample Documentation Language

“At 2:45 PM, resident stopped eating, stared blankly for ~25 seconds, no verbal response. Mild right hand tremor noted. After episode, resident appeared confused and required assistance to bed. Charge nurse notified.”

Think About This

Would your note provide enough detail for a provider to understand what happened? Would reviewing it later help identify a seizure pattern?