

SLEEP ASSESSMENT

1. History: Resident has a history of:	Yes	No
a. chronic insomnia		
b. intermittent insomnia		
c. no prior insomnia		

2. Type of disturbance The resident has:	Yes	No
a. complaints of not getting enough sleep		
b. difficulty falling asleep	Yes	No
nursing observes <i>time of night:</i>		
resident states <i>time of night:</i>		
c. evening awakening	Yes	No
nursing observes <i>time of night:</i>		
resident states <i>time of night:</i>		
d. length of time asleep	Hours	
nursing observes :		
resident states		

3. Sleep hygiene. The resident:	Yes	No
a. naps during the daytime		
b. stays in bed frequently during the daytime		
c. is able to ambulate / exercise		
d. consumes caffeinated beverages		
e. is taking medications which can possibly contribute insomnia		
<input type="checkbox"/> theophylline <input type="checkbox"/> decongestants <input type="checkbox"/> SSRI antidepressants <input type="checkbox"/> Ritalin <input type="checkbox"/> amphetamine <input type="checkbox"/> Norpramin <input type="checkbox"/> MAOIs <input type="checkbox"/> nicotine patches <input type="checkbox"/> beta/calcium blockers <input type="checkbox"/> albuterol/Serevent/Combivent <input type="checkbox"/> other: _____		
f. requires toileting \ personal care during bedtime hours		
g. has medication administration during bedtime hours		

4. Environment The resident's room is located close a source of noise:	Yes	No
<input type="checkbox"/> nursing station <input type="checkbox"/> noise outside the building <input type="checkbox"/> instrumentation <input type="checkbox"/> overhead sound system <input type="checkbox"/> ventilation duct <input type="checkbox"/> residents in other rooms w/noise <input type="checkbox"/> other _____		

5. Roommate: During night the roommate:	Yes	No
<input type="checkbox"/> makes noises <input type="checkbox"/> requires nursing intervention <input type="checkbox"/> uses instrumentation <input type="checkbox"/> other _____		

6. Psycho-social stressors The resident has:	Yes	No
<input type="checkbox"/> family stress <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> psychosis <input type="checkbox"/> suspiciousness <input type="checkbox"/> angry/hostile <input type="checkbox"/> placement issues <input type="checkbox"/> financial issues <input type="checkbox"/> other _____		

Resident: _____

SLEEP ASSESSMENT

	Yes	No
7. Pain The resident:		
a. has a pain related diagnosis.		
b. receives routine pain medication.		
c. has received a prn pain medication in the last 30 days.		
d. Pain been ruled out as a source of the sleep disturbance.		

	Yes	No
8. Non-Drug interventions The resident:		
a. is willing try non-drug interventions.		
b. has failed non-drug interventions.		

	Yes	No
9. Diagnoses which may contribute to insomnia:		
a. Cardiac / CHF / arrythmias / ASHD		
b. Dementia / Alzheimer's / Lewy body / MID		
c. Parkinson's / supranuclear palsy		
d. Restless leg syndrome / nocturnal leg cramps		
e. Sleep apnea / COPD		
f. substance abuse history (tobacco / alcohol / other)		
g. urinary / bowel - frequency / incontinence		

	Yes	No
10. Family / Resident circumvention		
The resident or family called the physician directly to obtain a hypnotic order.		

	Yes	No
11. Statements		
a. The resident has been admitted with a hypnotic order or the physician ordered the hypnotic without nursing input or assistance.		
b. The resident has a chronic use history which has been deemed by the physician to be safe, effective, and improving the resident's quality of life. Reduction attempts will be reviewed once the resident's other medical conditions have stabilized.		
c. The resident with a dementia diagnosis has shown signs of a sleep disturbance which cause functional impairment: interferes with the their ability to obtain a sufficient energy level, ability to focus, or attentiveness to participate in therapy, eating, visits, groups, or other activities of daily living.		

Summary:

Action:

Resident:

