Sleep Assessment

Date: _____

Type of Assessment: ❑ **Initiation of new hypnotic** ❑ **Annual or quarterly review** ❑ **Condition change**

Current ADL Function for most ADL's: ❑ Independent ❑ Assist of 1 ❑ Assist of 2 or more ❑ Dependent

INTERVIEW:

1. **Are you taking medications to help you sleep?** NO ❑ YES ❑ If yes, average frequency _____/Month
2. **If yes:** Medication: _____ Dose: _____ Time Taken: _____
   Medication: _____ Dose: _____ Time Taken: _____
3. **What is the average number of hours you sleep each night?** _____(Hours)
4. **Do you nap during the daytime?** YES ❑ NO ❑ Number of naps/day: _____
   Times of naps: _____
5. **Do you wake up during the night?** YES ❑ NO ❑ if yes, number of times: _____
6. **What is the reason you get up during the night?** _____
7. **Are you able to fall back asleep when awakened?** YES ❑ NO ❑ Describe: _____
   _____
8. **How long does it take you to get back to sleep?** _____
9. **If unable to sleep at night, when did this start?** _____
10. **Why do you think you are unable to sleep at night?** _____
11. **What have you tried in the past to help you sleep at night?** _____
    _____
12. **Have you started any new medications within the past 30 days?** YES ❑ NO ❑
13. **Do you exercise during the day?** YES ❑ NO ❑ If yes, number of hours/day: _____ Time of day: _____
14. **Describe what you do for exercise:** _____
    _____
15. **Check the following that apply:**

    ❑ Noise bothers you at night ❑ You have difficulty with breathing at night ❑ Light at night bothers you
    ❑ Pain prevents you from falling asleep ❑ Pain wakes you up or interferes with your sleep
    ❑ You drink caffeine after 5:00 pm ❑ You eat chocolate after 5:00 pm
    ❑ Indigestion bothers you during the night ❑ Urinary frequency is a problem at night
    ❑ You wake up hungry during the night ❑ You frequently wake up too cold/hot (Circle)
    ❑ You wake up snoring or someone has told you that you snore at night
    ❑ You feel as if your legs are restless at night
    ❑ You feel depressed (describe): _____
    ❑ You feel worried (describe): _____
    ❑ Other: _____

8. **Why do you feel you have problems sleeping at night?** _____
   _____

Name: _____ MR#_____ Room#_____

9. **Have you noticed a decline in your function since taking sleep medication?** YES ❑ NO ❑ Describe: _____
_____

10. **Do you have difficulty waking up in the morning?** YES ❑ NO ❑

_____

11. **Do you feel well rested when you wake up in the morning?** YES ❑ NO ❑

12. **Check the following interventions that resident is willing to try to promote sleep:**

❑ Soft Music ❑ Warm milk ❑ Night-time decaffeinated tea ❑ Relaxation Techniques
❑ Daily exercise ❑ Back rub ❑ Pain medication ❑ Elimination or reducing time of daytime naps
❑ Dim nightlight or change in lighting ❑ Other (List): _____
_____

NURSING STAFF:

13. **Has gradual dose reduction (GDR) been attempted consistent with facility policy?** YES ❑ NO ❑

*** Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.**

14. **Complete Sleep Pattern Flow Sheet for 4 days to identify pattern.** YES ❑ NO ❑

15. **Care plan reviewed and revised for medication and non-pharmacological interventions, goals and monitoring:**
❑ Yes ❑ No

Comments: _____
_____
_____

Nurse Signature: _____ **Date:** _____

IDT Signatures:

_____ _____
(Signature) (Date)

_____ _____
(Signature) (Date)

_____ _____
(Signature) (Date)

_____ _____
(Signature) (Date)

Name: _____ MR#_____ Room#_____