

Critical Care Patient Sleep Survey

1. How would you rate the quality of your sleep last night? Good / OK / Poor
2. How often did you find yourself awake last night? Rarely / Occasionally / Often
3. How difficult was it to return to sleep last once awake? Easy / Ok / Difficult
4. What is your quality of sleep like at home normally? Good / Average / Poor
5. Please rate how the following affected your sleep: *(1 = not disruptive - 10 = very disruptive)*

*(Please circle)*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Noise | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Light | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Nursing interventions (e.g. turns, bed bath) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Treatment interventions (e.g. Chest x-ray, bloods) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Medicines administration | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Other (please state) |  |

1. Please rate how disruptive the following NOISES were to your sleep in the critical care unit:

(1 is no disruption, 10 is significant disruption)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Monitor/ventilator/other alarms | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Staff Talking | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Other patients or relatives | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Suctioning  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Doctors bleeps | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Telephones | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Televisions | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Other (please state) |  |

1. Did any of the following make sleep more difficult:

Pain Yes No A bit

Feeling frightened / anxious Yes No A bit

Having tubes drips or drains Yes No A bit

1. Were you offered a sleep pack (Ear plugs and eye mask)? Yes No

Did you use a sleep pack? Yes No

If you used a sleep pack, did it help? Yes No

1. Could we have done differently to improve your sleep? (please state):

 Thank you for completing this survey

*This section to be completed by staff member*

Patient details

Age Sex

1. Type of patient
	1. Medical or surgical with no operation
	2. Emergency surgical post-operative
	3. Elective surgical post-operative
2. Number of nights on critical care -
3. Was the patient sat out of bed the previous day?
4. Has the patient previously been on an infusion of sedative medicines e.g. Propofol or midazolam? Yes /No
5. Has the patient ever been diagnosed with delirium or confusion? Yes / No
6. Circle any of devices the patient has in situ:

CVC Arterial line, Urine catheter, NG tube Tracheostomy Abdominal wound, Other surgical wound

Other device or wound: (*please list)*

1. Night sedation:

Was night sedation requested by the patient? Yes / No

Was night sedation offered? Yes / No

Was night sedation given? Yes / No

Was night sedation declined by the patient? Yes / No