Critical Care Patient Sleep Survey

West Yorkshire
Critical Care & Major Trauma
Operational Delivery Networks

We are always looking to improve our service; as such we would be grateful if you would complete this short 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)

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

6. Please rate how disruptive the following NOISES were to your sleep in the critical care unit:
   (1 is no disruption, 10 is significant disruption)

a) Monitor/ ventilator/ other alarms	1	2	3	4	5	6	7	8	9	10
b) Staff Talking	1	2	3	4	5	6	7	8	9	10
c) Other patients or relatives	1	2	3	4	5	6	7	8	9	10
d) Suctioning	1	2	3	4	5	6	7	8	9	10
e) Doctors bleeps	1	2	3	4	5	6	7	8	9	10
f) Telephones	1	2	3	4	5	6	7	8	9	10
g) Televisions	1	2	3	4	5	6	7	8	9	10
Other (please state)										

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

a)	Pain	***Yes***	***No***	***A bit***
b)	Feeling frightened/ anxious	***Yes***	***No***	***A bit***
c)	Having tubes drips or drains	***Yes***	***No***	***A bit***
d)	Hallucinations	***Yes***	***No***	***A bit***

8. 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***

9. 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
   a) Medical or surgical with no operation
   b) Emergency surgical post-operative
   c) 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)*

7. 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