

Subject #: _____
Time started: _____
Time finished: _____

Patient Sleep Assessment

Date patient approached: _____

Interviewer name: _____

Hello [insert name]:

Hello. My name is [insert name] and I would like to touch base with you again concerning your ability to sleep last night while a patient at the University of Chicago hospital.

You are being asked to take part in this study in order for us to learn more about sleep in hospitalized patients. If you agree to participate in this short interview, you will be asked to answer questions about you and your sleep habits in the hospital. This study will take about 10-minutes to complete. The information in this survey will be used anonymously for research purposes and will not be shared with anyone.

If you wish, you may decide not to answer any of the questions.

Karolinska Sleep Log¹
To be completed each *morning*

The following questions refer to your sleep last night.

1. At what time did you go to bed and turn the light off last night? _____ PM or AM
2. At what time did you arise this morning? _____ PM or AM
3. How long did you sleep? _____ hours & _____ minutes
4. How long did it take you to fall asleep? _____ hours &/or _____ minutes
5. How many awakenings did you have last night? _____
6. How many total minutes were you awake after falling asleep last night? (*Don't include time in bed before falling asleep*) _____ minutes

Circle one per question only:

7. How did you sleep?

| | | | | |
|-------------|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 |
| Very Poorly | | | | Very Well |
8. Did you feel refreshed after you arose this morning?

| | | | | |
|------------|---|---|---|------------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | | Completely |
9. Did you sleep soundly?

| | | | | |
|---------------|---|---|---|--------------|
| 1 | 2 | 3 | 4 | 5 |
| Very Restless | | | | Very soundly |
10. Did you sleep throughout the time allotted for sleep?

| | | | | |
|------------------------|---|---|---|----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Woke up much too Early | | | | Slept thru the night |
11. How easy was it for you to wake up?

| | | | | |
|-----------|---|---|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Very Easy | | | | Very Difficult |
12. How easy was it for you to fall asleep?

| | | | | |
|-----------|---|---|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| Very Easy | | | | Very Difficult |
13. How much did you dream last night?

| | | | | |
|------|---|---|---|------|
| 1 | 2 | 3 | 4 | 5 |
| None | | | | Much |
14. How much was your sleep disturbed by noise?

| | | | | |
|------------|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | | Very much |
15. How much was your sleep disturbed by stress?

| | | | | |
|------------|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | | Very much |

Did you remove the Actiwatch at any time? If so when and for how long?

¹ Keklund G, Akerstedt T. Objective components of individual differences in subjective sleep quality. J Sleep Res. 1997;6(4):217-20.

Potential Hospital Sleep Disruptions and Noises Questionnaire^{2,3}

Please rate the extent to which each of the following disrupted your sleep last night. 1 is not disruptive at all, 2 is somewhat disruptive, 3 is moderately disruptive, 4 is quite a bit disruptive and 5 is extremely disruptive.

| | | | | | |
|-----------------------------|---|---|---|---|---|
| Vital signs | 1 | 2 | 3 | 4 | 5 |
| Medications | 1 | 2 | 3 | 4 | 5 |
| Drawing blood or other test | 1 | 2 | 3 | 4 | 5 |
| Pain | 1 | 2 | 3 | 4 | 5 |
| Feeling anxious | 1 | 2 | 3 | 4 | 5 |
| Noise (all sources) | 1 | 2 | 3 | 4 | 5 |
| Staff conversation | 1 | 2 | 3 | 4 | 5 |
| Alarms on equipment | 1 | 2 | 3 | 4 | 5 |
| Bed comfort | 1 | 2 | 3 | 4 | 5 |
| Room temperature | 1 | 2 | 3 | 4 | 5 |

² Modified from Gabor JY, Cooper AB, Crombach SA, Lee B, Kadikar N, Bettger HE, Hanly PJ. Contribution of the intensive care unit environment to sleep disruption in mechanically ventilated patients and healthy subjects. *Am J Respir Crit Care Med.* 2003;167(5):708-15.

³ Modified from Topf, M, Personal and Environmental Predictors of Patient Disturbance Due to Hospital Noise. *Journal of Applied Psychology.* 1985; Vol. 70, No. 1: 22-8.

Epworth Sleepiness Scale⁴:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

| Situation | Chance Of Dozing |
|---|------------------|
| Sitting and reading | |
| Watching TV | |
| Sitting inactive in a public place (e.g a theater or a meeting) | |
| As a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon when circumstances permit | |
| Sitting and talking to someone | |
| Sitting quietly after a lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |

⁴ Johns, MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. Sleep. 1991;(14):540-5.