

SLEEP AND ACTIVITY

DIARY

Name: Room:

CONTACT DETAILS

Emma Cope

Tel: 01483 684622



# Identification Number:

**Room**: single / shared **Window facing**: North / South / East / West

**En-suite:** Yes/No

**Number and location of windows:**

**Light fittings:**

**Description of the bedroom including layout and furnishing:**

**Prescribed and unprescribed Medication and time medication is taken**

**Hearing aid**: Yes/No Left Ear/ Right Ear/ Both Ears

**Sight:** Wears glasses Yes/No Wears contact lenses Yes/No

Clear Vision/Clouded Vision Partially Sighted/Blind

**Age**: 60-64 □ 65-69 □ 70-74 □ 75-79 □

80-84 □ 85-89 □ 90-94□ 94-99 □ 100-104 □

**Gender**: Male / Female

**Dependency level** (see below for criteria):

(Based on information from care home staff)

**Care level 0**: Needing no assistance

**Care level 1**: Daily at least 90 minutes of care to be required, of which at least 45 minutes are spent on basic care

**Care level 2**: Daily at least three hours of care required, of which at least 2 hours are spent on basic care

**Care level 3**: Daily at least 5 hours of care required, of which at least 4 hours are spent on basic care

**Please tick or underline the appropriate response to the following:**

**Continence care:**

What is used to manage continence care during the **day?** There can be more than one answer:

|  |  |
| --- | --- |
| Pads |  |
| Catheters |  |
| Toilet assisted |  |
| Other please state |  |

Please state how continence care, during the day, is provided:

|  |  |
| --- | --- |
| On demand by the resident |  |
| Regular intervals |  |
| Assist themselves |  |
| Other please state |  |

What is used to manage continence care during the **night?** There can be more than one answer.

|  |  |
| --- | --- |
| Pads |  |
| Catheters |  |
| Sheets (e.g. Kiley) |  |
| Special mattress |  |
| Commode/bedpan |  |
| Urine bottle |  |
| Toilet assisted |  |
| Other please state |  |

Please state how continence care is managed during the night:

|  |  |
| --- | --- |
| On demand by the resident |  |
| Regular intervals |  |
| Assist themselves |  |
| Other please state |  |

**Optional additional information:**

**ID:**

**Pittsburgh Sleep Quality Index**

Instructions: *the following questions relate to your usual sleep habits during the past month only. The answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions. For questions 5-9 please place a tick in the appropriate column.*

During the past month:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1.What time did you usually go to bed? | | | |  | | |
| 2. How long (in minutes) has it taken you to fall asleep each night? | | | |  | | |
| 3. What time did you usually get up in the morning? | | | |  | | |
| 4. How many hours of actual sleep did you get at night? (This may be different than the number of hours you spend in bed). | | | |  | | |
| 5. During the past month, how often had you had trouble sleeping because you….. | | Not during the past month | Less than once a week | | Once or twice a week | Three or more times a week |
|  | |  |  | |  |  |
| a. | Cannot get to sleep within 30 minutes |  |  | |  |  |
| b. | Wake up in the middle of the night or early morning |  |  | |  |  |
| c. | Have to get up to use the bathroom |  |  | |  |  |
| d. | Cannot breathe comfortably |  |  | |  |  |
| e. | Cough or snore loudly |  |  | |  |  |
| f. | Feel too cold |  |  | |  |  |
| g. | Feel too hot |  |  | |  |  |
| h. | Have bad dreams |  |  | |  |  |
| i. | Have pain |  |  | |  |  |
| j. | Other reason(s) |  |  | |  |  |
| 6. During the past month, how often have you taken medicine (prescribed or ‘over the counter’) to help you sleep? | |  |  | |  |  |
| 7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity? | |  |  | |  |  |
| 8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done? | | Not during the past month | Less than once a week | | Once or twice a week | Three or more times a week |
| 9. During the past month, how would you rate your overall sleep quality? | | Very good | Fairly Good | | Fairly bad | Very bad |

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**Very good Fairly good Fairly bad Very bad**

**2.** When did you go to bed last night?

**3.** When did you actually get to sleep?

**4.** Did you wake up during the night? YES NO

If YES how often did this occur?

If YES and you are able to recall the reason please tick or underline why you woke up:

Needed to go to the toilet

Noise in home

Dreams

You were in pain

Not sure

Other please state

**5.** When did you wake up this morning?

**6.** When did you actually get up this morning?

**7.** How were you woken up today?

Woke up naturally

Care Staff woke me

Inside noise

Outside noise

Alarm clock

Other

# We are interested in your routines during the day. Please tick or underline the answer which best reflects your day.

**8.** Using mealtime as guidance for the time of day please complete in the following table

|  |  |
| --- | --- |
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In the afternoon? YES NO None available

In the evening? YES NO None available

Optional additional information:

**We are interested in your routine for bedtime. Please tick or underline the answer which reflects what happens when you go to bed and sleep.**

**10**. Who got you ready for bed last night?

Yourself

With assistance of care staff

Care staff

Other please state:

**11.** What was the last thing you did before going to sleep?

Watched TV

Listened to the radio

Read

Had a drink

Go to the toilet

Other please state:

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