HUSH
(Help Us Support Healing)
Why Sleep Hygiene?

- Patient and family complaints/concerns around sleep quality
- Healthcare provider’s noting poor quality sleep in some patients
- Improved health outcomes for patients when quality sleep is achieved:
  - Sleep disturbances in elderly common
  - Increased wakefulness during the day to participate in therapies and interventions
Sleep Hygiene

- Is the individual behaviours and practices that one completes to prepare for and support sleep

- Changing the temperature to a cooler setting (or hotter)
- Reducing light (night light)
- Pain / sleeping / other medications
- Brushing teeth and washing the face
- Reading / TV / Radio
- ...etc.
Factors within our hospital environment contribute to the disruption of sleep for elderly patients and place them at risk for negative health outcomes associated with sleep deprivation.
What We Measured

- Baseline survey of current patient satisfaction of their sleep on the unit
- Baseline survey of nurses understanding of sleep hygiene
- Baseline environmental scan of the unit for current practices
- Formulate a focus group on the issue of sleep hygiene
- Look at gaps identified from the survey and focus group and develop an education plan for staff
- Use of dosimeters to measure noise levels
Sleep Disruption

Provider

- Hallway Conversation
- Disturbing patient during rounding
- Lack of awareness re: sleep in the elderly
- Existing sleep disorders
- Delirium
- Pain
- Voiding patterns
- Diet

Process of Care

- Medication times and frequency
- Delivery of linen times
- Late evening and night admissions
- Replenishing chart forms
- Desk noise
- Overhead pages
- Bed Moves during the night hours
- Bed Flow

Physical Environment

- Noise in the hallway
- Equipment noise - beeping IV pumps
- Bed noise & alarms
- Overhead pages
- Lights in hallways and patient rooms
- Temperature
- Phone alarms
- V/S cart wheels squeaking

Patient

- Overhead pages
- Bed Moves during the night hours
- Bed Flow

Organizational Support

- Lights in hallways and patient rooms
- Temperature
- Phone alarms
- V/S cart wheels squeaking

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Aim and Outcome Measures

Aim

By December 2016, sleep quality for patients 65 years and older, admitted to an acute medicine unit will be improved by 50%.

Outcome

Patient (self-reported) satisfaction of sleep (50% reduction in sleep complaints)

An increase in Nurse reported hours of uninterrupted patient sleep by 50%

50% increase in Patient alertness levels as reported by nursing, allied health, MD, during daytime activities
Balancing Outcomes

- % Change in nursing workload
- Number of missed alarms or calls related to lower sound volumes
- Change fatigue related to a number of ongoing projects and rolling concurrently
Created Standard Work for Staff

- Provide patient with warm blanket
- Offer back rub or foot massage (encourage family involvement)
- Stocking charts in TCC away from patient rooms
- Dim lights in the evening hours
- Set room temperature to patients preference
- Assist with personal hygiene and toilet prior to bed
- Encourage reading prior to sleep hours
- Keep noise to a minimum

- Implementation of “Quiet” hours and enforcement of visiting hours
- Signage - HUSH (Help Us Support Healing)
- Schedule activities to provide uninterrupted sleep (timing of medication administration, assessments, etc.)
- Maintain patient usual bedtime
- Provide pain medication 30 mins prior to bedtimes
- Offer bedtime snack or beverage (warm milk)
- Encourage communication amongst health care team in regards to patient preferences and specific sleep hygiene interventions
Anticipated Barriers and Mitigation Strategies

- Staff engagement (attitudes, beliefs)
- Admitting practices
- Delivery practices
- Money, resources, signage, medication practices/times,
- Competing priorities (MoNCP, Intentional Rounding, etc.)
Patient (self-reported) satisfaction of sleep

During hospitalization, how would you rate your sleep quality overall?

- When asked about sleep quality prior to hospitalization, 100% of patients surveyed in June felt their sleep quality at home was good/very good compared to 77% in February.
Nurse-reported hours of sleep
Nurse observed patient sleep hourly from 2100-0900h

<table>
<thead>
<tr>
<th>Time</th>
<th>Sleeping</th>
<th>Awake</th>
<th>No Obs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>JUN 2016 (10 PTS)</td>
<td>72%</td>
<td>23%</td>
<td>5%</td>
</tr>
<tr>
<td>FEB 2017 (8 PTS)</td>
<td>58%</td>
<td>31%</td>
<td>11%</td>
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Outcome Measures:
Decrease decibel reading outside patient room

Jun 2016: 56.4
Feb 2017: 45.7
Demonstrated understanding of what sleep hygiene is by nursing staff:

- June 2016: 54% Yes, 46% No
- February 2017: 100% Yes, 0% No
Staff Questionnaire - Are unit practices and environment conducive to quality patient sleep?

- Majority of nursing staff (91%) felt improvements have been made since moving to ACE unit:

- Areas for improvement were still identified by 55% of staff surveyed:
Key Challenges

- Change in team membership on numerous occasions
- The pilot unit was engaged in a number of other projects
- Key technological requirements for change implementation had been slow to uptake due to construction
Lessons Learned

- Project momentum can be influenced by a myriad of factors—anticipated this and planned accordingly.
- Knowing when to move ahead with change measures and when to pause for consideration when faced with challenges is key to success.
- Staff see how their input was utilized to advise change.
- Constant communication of project goals and proposed change ideas aided in ongoing recognition of project by staff.
- Timing of education was imperative.
What’s Next?

► Check it all again