Cutting Through the Foggy Myths Using Best Practice Guidelines in Long Term Care

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BP Blogger

Myth Busting: The Sleep Issue

Inside this issue:

Myth 1: We need less sleep as we get older

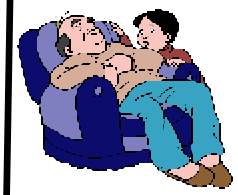
Roughly 1/3 of our lives is spent in sleep, yet there are still many things we don't understand about this important part of our lives. The National Sleep Foundation's (NSF) 2003 sleep poll suggests that older adults between the ages of 55-84 are sleeping well. Research has found that poor sleep is not a consequence of aging but is a result of medical conditions. Those who had 4 or more medical conditions

were more likely to sleep less than 6 hours. Older adults tend to do fewer new things and the sleep process of the brain filing and reorganizing becomes less significant, so fewer hours are spent within our sleep doing this. So the older adult's sleep requirements diminish. Minor age-related sleep changes are normal such as

- Increased nighttime awakenings
- More time in bed with less time spent sleeping
- Going to sleep earlier
- Waking up earlier
- Taking longer to fall asleep
- Decreased deep sleep
- Decreased REM sleep
- Increased daytime napping

Myth 2: Daytime napping leads to sleep problems

Minor age-related sleep changes such as increased napping that do not disrupt usual activities are considered normal. Daytime napping is reported by 25-80% of residents and 10-30% report excessive daytime sleepiness. Sadly, many factors in LTC amplify normal age-related sleep changes. Many LTC residents spend a large part of the day inactive, bored or even in bed. They often lack exposure to sunlight, a situation that may disrupt circadian rhythms and add to sleep problems. Residents who are blind or visually impaired may not be able to synchronize day-night cycles, resulting in daytime sleepiness. Disturbances in the sleep-wake cycle are common in residents with dementia, resulting in daytime sleep and nighttime wakefulness. Those with severe dementia may frequently sleep during the day. Some of the long-acting sleep medications can lead to excessive sleepiness. Research has shown that physical activity combined with recreation programs during the day ***plus*** other sleep promotion strategies, decreases daytime napping and improves nighttime sleep.



More information on This and Other Best Practices

- **Contact** your **Regional LTC Best Practices Coordinator.** They can help you with Best Practices Info for LTC. **Find them at:** **www.shrtn.on.ca** click on these links "Tools and Resources"➔"Current Research BP Practice Initiatives" ➔"LTC Regional BP Coordinators"
- **Check out** the **Hamilton Long Term Care Resource Centre**
- **Surf the Web** for best practice guidelines. Some sites and resources are listed on pg 2.

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Find it on the Web at www.rgpc.ca or www.shrtn.on.ca

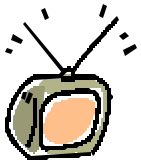
Myth 3: Young adults suffer from insomnia

Insomnia is the most common sleep complaint in older adults. Experts on sleep disorders agree that insomnia is a symptom and not a diagnosis. Insomnia is when older adults have difficulty falling asleep, difficulty staying asleep, early awakening, or complain of feeling tired in the morning that results in impaired physical, social or cognitive function. Insomnia in older adults is due to a combination of things. In LTC, new insomnia is usually transient and related to environmental or psychological stress, medication use, or worsening of a medical condition. Chronic insomnia (more than 3 weeks) is often related to medical conditions, pain, chronic medication use, depression, poor sleep hygiene, or a combination of all of these . In fact, the LTC home environment in addition to age-related changes and medical conditions common among older people—such as congestive heart failure, arthritis, diabetes, heartburn, incontinence, pain, itchy skin, asthma, shortness of breath, allergies, depression and others— medications that affect sleep, or substance abuse can all contribute to sleep difficulties in residents. Pain is a sleep stealer. Residents with pain can lose more than 2 hours of sleep at night.

Myth 4: LTC homes don't promote quality sleep

Although it is important to treat medical conditions such as pain, heartburn and shortness of breath; it is equally important to address environmental, behavioural and psychosocial factors that may aggravate sleep difficulties. Environmental changes alone are not enough, a combination of strategies seems to work best to improve sleep in LTC residents.

Principles of Good Sleep Hygiene



Choose a combination of strategies :

Behavioural ***Encourage:***

- daily physical activity & recreational activity. If done in isolation of each other, these programs are unlikely to have a significant impact on sleep.
- going to bed when sleepy and getting up at a consistent time every day
- regular exposure to sunlight, light therapy benefits for residents with dementia are minimal
- use of relaxation techniques
- "winding down" before bedtime. Too much activity late in the evening can be stimulating, making it difficult to relax for sleep.
- limiting use of psychoactive drugs. Benzodiazepines, neuroleptics and antidepressants do not appear to substantially improve residents' sleep.
- eating a light snack before bedtime and avoid excessive fluid consumption
- doing something, getting up if unable to sleep. Don't watch TV as its stimulating and emits too bright a light.

Discourage :

- spending excessive time in bed when not sleeping
- taking alcohol, caffeine and nicotine within 4h of bedtime,
- frequent daytime naps
- looking at the clock during the night, it can cause more anxiety

Environmental

- Minimize noise and light at night
- Maintain appropriate room temperature, about 65°F or 18°C
- Offer a warm bath 2h before bedtime

Psychosocial

- provide time to adjust and deal with relocation, anxieties, bereavement, family situation
- Encourage interaction to avoid social isolation

Check out these Best Practices & Guidelines. Answers to the Myths came from them. Find out more!

Canadian:

Canadian Sleep Society. www.css.to/

Others:

American Medical Directors Association. (2006). Sleep disorders. Clinical practice . Columbia, MD: AMDA.www.amda.com

Australian Centre for Evidence Based Aged Care (ACEBAC) (2004). Best practice: Strategies to manage sleep in residents or aged care facilities. *8*(3). Melbourne, Australia: Joanna Briggs Institute. www.joannabriggs.edu.au

Umlauf, MG., Chasens, ER., & Weaver, TE. (2003). In Mezey, M., Fulmer, T., Abraham, I., & Zwicker, DA.(Eds).Geriatric nursing protocols for best practice *(2nd ed.)*. New York, Springer Publishing Company, p.47-65.

National Sleep Foundation. www.sleepfoundation.org

American Academy of Sleep Medicine. www.aasmnet.org

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