

SUBJECT: ADMISSION ASSESSMENT	REFERENCE #2004
DEPARTMENT: SLEEP LAB	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- Upon admission to the Sleep Lab, each patient will have an assessment completed by the technologist for data collection and to determine any immediate needs or concerns.
- Admission assessment will include the following:
 - Review of demographic information
 - Reason for sleep study
 - Physiological parameters
 - Current medications
 - Environment - special needs of the patient, i.e., hearing aid, glasses, cane, interpreter
 - Patient/family education
 - Discharge planning:
 - Where
 - With whom
 - Reminder to patient to make follow-up appointment with referring physician

PROCEDURE:

- Greet patient and introduce self.
- Identify patient and place ID band on patient's wrist.
- Orient patient to room.
- Complete Admission Assessment Form.
- Ensure informed consent is signed.
- Review Patient Prestudy Questionnaire.

SUBJECT: ROUTINE POLYSOMNOGRAPHY (PSG)	REFERENCE #3005
DEPARTMENT: SLEEP LAB	PAGE: 1
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APPROVED BY:	EFFECTIVE:
	REVISED:

PURPOSE:

Sleep studies are performed to evaluate and diagnose possible sleep disorders complicated by cardiopulmonary dysfunctions.

POLICY:

- A qualified sleep lab technologist will be in attendance for the entire sleep study.
- The technologist will notify the referring physician and/or Medical Director of any emergent situations, unusual observations during sleep study.

INDICATIONS:

- Polysomnography is indicated in patients with:
 - Restrictive ventilatory disorders due to neuromuscular disease and manifesting symptoms of sleep disturbances that include:
 - Morning headaches
 - Somnolence
 - Fatigue
 - Complicated by polycythemia or pulmonary hypertension
 - COPD complicated by a PaO₂ over 55 mm Hg, complicated by pulmonary hypertension, right heart failure or polycythemia,
 - Respiratory disturbances and a PaCO₂ of 45 or greater.
 - Sleep apnea, either by history or with complaints of excessive snoring and daytime somnolence.
 - Nightly cyclic brady or tachy arrhythmias that appear to increase in frequency during sleep.

SUBJECT: PRE-STUDY PATIENT REQUIREMENTS	REFERENCE #3002
DEPARTMENT: SLEEP LAB	PAGE: 1
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APPROVED BY:	EFFECTIVE:
	REVISED:

POLICY:

Pre-study requirements will be reviewed with the patient prior to the sleep study via information brochure sent to patient and during the reminder call.

PROCEDURE:

- Instruct Patient to:
 - Continue medications ordered by physician.
 - Bring all medications and respiratory equipment, if applicable.
 - If the patient is diabetic, remind patient to bring insulin and a snack.
 - If the patient is taking sleeping pills, consult with Medical Director. (Patient may be required to stop all sleeping medication ten (10) days before the sleep study.
 - Eat dinner before coming to the sleep lab.
 - Do not consume large amounts of caffeine 12 hours before the sleep study.
 - Do not consume any alcohol.
 - Do not take a nap during the day of the sleep study.
 - Do not use hairspray, gels, mousse, etc., the day of the sleep study.
- Review Patient Checklist with patient.
- Encourage patient to have a family member/significant other drive the patient to and from the sleep lab or use public transportation.

The technologist shall consult with the Medical Director about any problems or concerns.

POST SLEEP STUDY QUESTIONNAIRE

Please mark your answers and fill in the blanks where applicable.

1. How long did it take you to fall asleep last night?
 Immediately Few minutes Hours Did not fall asleep
2. How does this compare to the time it usually takes you to fall asleep?
 Same Shorter time Longer time
3. How many hours of sleep do you think you got? _____
4. How does this compare to the amount of sleep you normally get?
 Same Less than normal More than normal
5. Did you dream? Yes No
6. How much dreaming do you remember?
 None Less than usual More than usual
7. Did you wake up?
 More than usual Same Less than usual
8. How many times do you remember waking up before the end of the study? _____
Why did you wake up? _____
9. How did you feel immediately after you woke up?
 Sleepy Somewhat alert Wide awake
10. How did you feel 10 to 15 minutes after waking up?
 Sleepy Somewhat alert Wide awake
11. In general, how did you sleep?
 Poorly Same as usual Better

Please answer questions 12-16 if you used CPAP/BiPAP.

12. How did you tolerate the mask and pressure?
 Poorly Well Very well
13. Do you feel rested? Yes No
14. Do you think you snored less when using CPAP? Yes No
15. How did you sleep with CPAP?
 Better Same as usual Worse
16. Please explain any problems you had with the CPAP therapy: _____

Thank you for completing this questionnaire.

Please remember to make an appointment with your physician to discuss the results of your sleep study.

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

SUBJECT: EMERGENCIES AND RESPONSES	REFERENCE #3016
DEPARTMENT: SLEEP LAB	PAGE: 1
	OF: 3
APPROVED BY:	EFFECTIVE:
	REVISED:

POLICY:

- The technologist will follow established guidelines for emergencies during a sleep study to ensure safety and care of patients.
- If there is any question of patient safety, call the Medical Director
- The polygraph recording will continue during the emergency uninterrupted.
- Disconnected headbox immediately prior to defibrillation.

PROCEDURE:

Emergency Situation	Response
• Chest pain, neck, jaw or arm pain	• Call Medical Director
• Mild to moderate difficulty breathing	• Call Medical Director
• Severe difficulty breathing	• Call 911
• Seizures without cardiac arrest	• Turn patient on side in case of vomiting. Call Medical Director
• Symptoms of stroke, i.e., paralysis, weakness of limbs, difficulty speaking, difficulty comprehending	• Call 911
• Headache - moderate to severe	• Page referring physician
• Nausea/vomiting	• Page referring physician
• Fall/injury	• Page night supervisor Notify referring physician
• Change in behavior, i.e., agitation, hostility, anxiety	• Page referring physician Page night supervisor or Security if needed