

LETTER TO THE EDITOR

Improve night sleep in critical patients[☆]



Mejorar el sueño nocturno de los pacientes críticos

We read with interest the article published by Carrera-Hernández et al.¹ on the perception of sleep in adult patients admitted to an Intensive Care Unit, which also sought to identify factors impeding night sleep. We want to congratulate the authors on their paper and to offer data from study that we performed in our Unit.

Ours is a 30-bed medical-surgical ICU in a tertiary level university hospital. In 2017 we undertook a survey to discover the quality of sleep in the unit and to identify factors that might be disturbing it. Our sample comprised 150 patients (63% surgical), 62% were male with a mean age of 60. Fifty-nine point three percent of the respondents answered that they had not slept well in the Unit. Monitoring vital signs during the night was the single factor that was associated in a statistically significant way with their not having slept well ($p = .001$). In our survey, noise ($p = .21$) or light ($p = .46$) in the Unit were not associated with sleep problems. We also analysed sex ($p = .73$), personal history such as previous use of hypnotics ($p = .62$), previous sleep disturbance ($p = .16$) or a history of psychiatric disease ($p = .24$) and found no statistical association.

Lack of sleep and disturbed sleep in ICU are problems that affect a major part of critically-ill patients (almost 60% according to our data), have negative consequences for their physical and mental recovery and constitute a risk factor for developing delirium. A recent document by SEMICYUC (The Spanish Society of Intensive and Critical Care Medicine and Coronary Units) recommends preventing the development of delirium by facilitating sleep through controlling light, noise and night-time stimuli.²

In contrast to the findings of Carrera-Hernández et al.¹ and those of another recent study on patients in the

postoperative period following heart surgery,³ noise is not a factor that disturbs sleep in our ICU. Because noise is largely due to human factors, principally conversations between healthcare staff and at specific times such as shift changes,⁴ this might be explained by layouts with closed cubicles and noise level metres used throughout the Unit to warn of noise levels, which we also found interesting.

Our data clearly indicate that we must assess on a daily basis whether the clinical stability of patients in our Unit will allow longer intervals between night-time care and monitoring (non-invasive arterial pressure monitoring, hourly urine output measurement, glycaemia controls, etc.) and thus facilitate their sleep. With the aim of promoting sleep, the question “can night-time checks be spaced out more?” is included in the Shared Objectives Registry completed jointly by both nursing and medical staff.

The main weakness of our study is that we did not use a validated scale for critical patients such as the Richards-Campbell Sleep Questionnaire. However we wanted to share our findings and stress the importance of identifying the factors that affect our patients’ rest in each Unit. These factors can be common in many cases and specific individuals given the structural characteristics of the Unit, types of patient and organisational model. We are all committed to humanising care in Intensive Care Units.⁵ Therefore, avoiding all factors that hinder our patients’ rest and night-time sleep is an essential part of this challenge.

References

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