Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Places to Flourish

A pattern-based approach to foster change in residential care

Getting Up And Settling Down

The ATLANTIC Philanthropies

University of ULSTER

Institiúid Teicneolaíochta Dhún Dealgan
DUNDALK INSTITUTE OF TECHNOLOGY

NHI nursinghomesireland

Getting Up and Settling Down

Introduction

"You can't turn the clock back. I have retired but I would still rather be working. I am happy here. I have been here almost a year now. I get plenty to eat and enough cigarettes. I would like to get outdoors more. The staff are alright. They have rules and you have to abide by them, but I get on ok with all of them. I spend a lot of time on my bed but I don't sleep well at night. I miss my family"

Sleeping and waking are normal and essential patterns of life. Sleep is an essential physiological need and without it we would die! However, throughout our lives our need for sleep changes as do our sleep patterns. In addition, we all have rituals associated with sleeping and waking that have probably been built up over many years and do not change significantly. In this section we explore patterns associated with 'getting up and settling down', two factors associated with successful beginning and ending of the day.

Getting Up and Settling Down: A Typical Example

It is 19.30 in Bayview nursing home which operates from a philosophy of resident-centredness articulated through the 'household model'. In this block, 8 residents live – 5 women and 3 men. The evening meal has been served and some members of the care team are clearing away the dishes from the tables. Three residents have already gone to their bedrooms and are getting themselves settled for the night – one has changed into his pyjamas and is watching television and having a beer. Another is having an early night and is already asleep (she previously worked as a Post-mistress and was used to going to bed early so that she could be ready to receive the early morning post for sorting at 5am). The other resident is with her family in her bedroom, sorting through clothes and planning her outfits for the weekend – she won't go to bed until later as today her daughter has offered to help her have a shower and set her hair before settling for the night. Rose House have supported her to continue to do so. Maureen likes to finish her day out with a small whiskey before returning to Rose House for supper. The staff know that she can become argumentative and uncooperative should something delay or disrupt her plans. They also know that some less mobile residents, such as Brigid, need assistance to use the bathroom at this time. Brigid is confined to a

wheelchair but is a very active member of the home, enjoying painting, gardening, reading and discussion politics Ann who live in the room next to her.

Meg is still in the kitchen/dining room chatting with Gary who is having his post-dinner scotch whisky. Meg has moderate dementia and whilst her level of orientation is poor, she manages to hold a conversation with others – not always a coherent conversation, but one that on this occasion Gary is enjoying engaging in. When Meg moved into Bayview she spent some weeks completing a life-review document with members of the care team – the nurse coordinated it, but various care workers completed aspects of it with Meg and members of her family, until they reached a stage where they felt they knew her daily patterns fairly well. They know that Meg rarely goes to bed before 10.30pm.

They also know that:

Before going to bed, Meg likes to…

- have time to sit and read the daily paper – she can sometimes spend 1-2 hours doing this
- have a mug of hot chocolate or 'Horlicks' – she usually alternates these and will say which she prefers on the night
- have her nightdress warmed on the radiator before putting it on
- have her fluffy covered hot water bottle at the bottom of her bed near her feet
- Wash her hands and face and remove her makeup
- Put her hair in a net
- Pass urine and have an incontinence pad and pants put on

To be able to go to sleep, Meg likes to …

- Have one of her pillows taken away as she only sleeps with one pillow – she says "I can't stand sleeping sitting up, I need to be flat!"
- Have a low level light illuminated in the room – makes her feel 'secure' and also helps her to find her way to the toilet in the night if she needs to
- Have the duvet tucked in around her - "cocoon like" she describes it
- Have her favourite doll to cuddle – Meg has been married for 48 years and found it very challenging to sleep on her own when she moved to Roselawns. In discussion with Meg and her family, the care team discovered that a doll (that she chose) helped her relax and to go to sleep
- Have the door to her room 'slightly ajar' (neither fully closed nor completely open)

Meg rarely gets up before 9am. She usually manages to get herself up from bed, but not before she has had a cup of tea and a read of her bible. She likes to be given her morning medications before she gets up and this is clearly stated in her care plan.

When getting up, Meg likes to …

- Remover her own incontinence wear and dispose of it in a special bin in her bathroom.
- Put on her dressing gown and slippers, remove her hair net and comb her hair
- Wash her face and put on her lipstick

Sometimes Meg needs assistance with these activities, but mostly she is able to attend to them independently. She likes to do these things before coming to the kitchen/dining room for breakfast. She is not very 'chatty' in the morning and can be a bit grumpy if her routine gets altered for any reason. Even Gary (who she enjoys chatting with) knows this and he usually avoids her in the morning!

But Think …

The Challenges: at the same time as Meg wants to go to bed, there may be 2 or 3 others who also want to go to bed, each with their own particular routine. It is often a time when there is fewer staff on duty. The registered nurse(s) on duty may be tied up with other tasks such as the administration of medications and particular treatments or in completing necessary documentation for the shift. There is usually few if any administrative staff around to answer phone calls. It is often a time when families visit and want to speak with care team members about their family member and particular care issues/compliments/complaints. It is the end of the day; everyone is feeling a bit 'jaded' and for residents who have a dementia their tiredness can cause them to be increasingly anxious (shown in ways of being such as calling out, wandering, requesting attention etc) and care team members are keen to get home.

At the same time as Meg is getting up, all of the other residents are awake and in various stages of getting up. Other residents may have various therapeutic care needs that require the specific attention of the registered nurse(s) on duty. A team member may have called in 'sick' leaving you short of staff to do everything planned.

Whilst all of these individual care needs require careful planning of how the day is organised and how individual residents' settling down and getting up patterns are to be planned for, sometimes the temptation to return to a more 'routinised' way of working can be very attractive in order to 'get the work done'. These individualised ways of working and avoidance of institutionalised routines require care team members to be flexible and adaptable and to have effective means of communication in order to be able to adjust plans as the day progresses.

Some Helpful Tips

- Plan your work with team members at the beginning of the shift and don't just start 'doing' without that plan.
- Be attentive to how residents' moods and behaviours change during the day as this may indicate degrees of tiredness and so may need to go to bed at a different time than usual.
- If you are feeling pressurised with work demands, talk to your manager or a colleague who can help you to adjust priorities.
- Include relatives and family members where possible as many are willing to help with some of the routines associated with helping their family member to get ready for bed.
- Be realistic in what you can achieve – each day will be different and so what worked yesterday may not work today – be flexible!

Getting Up and Settling Down : Patterns of Activity

As we have stated at the outset, sleep is a physiological requirement and a necessary part of being healthy. Without sleep we would die – not just from physical and mental exhaustion, but from a range of physical and mental conditions associated with a lack of sleep. As we age, good quality sleep is especially important as it helps with concentration and the storing of memories (Siegel 2001), as well as helping with repairing cells, boosting the immune system and generally preventing disease. A person normally goes through 4-6 sleep cycles which begin with a 'pre-sleep' period during which time the person is conscious of 'feeling sleepy. Once asleep the stages of cycles that help the person move from light sleep to deep sleep and it is thought that these occur in 90-minute cycles (Kryger et al 2000). The final stage known as 'REM [Rapid Eye Movement' Sleep] is when the person dreams and is the deepest level of sleep. These cycles may occur for different durations and are also dependent on the total time the person is asleep.

As we age, what we know to be our 'typical' sleep pattern may change and we may notice differences emerging in our need for sleep, the number of hours we actually sleep and in our waking and sleeping pattern. It is thought that the area of the brain that controls sleep, changes as we age and causes variability in the older person's sleep pattern. The quality of sleep deteriorates as we age. Most older people do not have difficulty with 'falling asleep' but do have difficulties associated with 'staying asleep'. Episodes of REM sleep tend to shorten. Sometimes when asked, the older person may state that they "have hardly slept" and this is thought to be associated with a lack of REM sleep. Older people sometimes wake earlier and take naps in the daytime to compensate for

these changes. How 'good' and 'poor' sleep are defined is a highly subjective issue and can only ever be based on how the person judges the quality of their sleep set against what they consider to be a usual pattern – the often used phrase of 'slept well' by care workers is completely meaningless unless it can be verified by the resident. Just because the person has their eyes closed and are not moving in or out of bed, does not mean that they have had a good sleep.

It is also the case that we each have particular rituals associated with settling down to sleep and with getting up. It is sometimes thought that ageing is associated with 'disturbed sleep' but there is no evidence to suggest that ageing alone causes sleep disturbances. Older people tend to have more fragmented sleep and can be awake for long periods in the night. Some people think that older people sleep much more than younger people, in fact the opposite is true and older people seem to sleep less overall. It is acknowledged however, that older people have to sleep for longer periods to get the same quality of sleep as a younger person and thus may spend longer periods in bed.

> *"I hate the twitchy legs syndrome as I call it! I know I need to get myself ready for bed when my legs twitch and I can't get comfortable no matter how hard I try. That's the time I ask the staff to get me my decaf-coffee and I head off to bed"*

If an older resident seems to be asleep a lot in the day, or appears to take multiple naps, then it is likely to be caused by disturbed sleep at night, boredom, inactivity, sedation or symptoms of disease. Sleep patterns can be severely disturbed when REM sleep is interfered with or stopped through the administration of sedatives or hypnotics or by repeated wakening (for example checking to see if the resident is 'dry'. Ironically the administration of sedatives and hypnotics can cause increased wakefulness and thus have the opposite effect of that intended. Long periods of sedation can reverse sleep patterns and cause residents to sleep for long periods in the day. It is widely recognised that the administration of such medications should be minimised as much as possible and instead, sleep should be facilitated by lifestyle changes, activity levels and comfort measures (Hughes et al 2008).

"I can't believe how much my sleep has changed over the years. There was a time when I could sleep for Ireland, I loved my bed and by 9 at night I usually could think of nothing else but going to my bed and being all nice and snug and secure. I was never a reader in bed and would be asleep before my head would hit the pillow! Jack and me always went to bed at the same time and I loved waking up in his arms. That's all changed now since I came here and I don't think about my bed in the same way. I miss waking up with Jack and I'm such a light sleeper now – anything at all wakes me up. They want me to move to a room on my own but I would be lonely and having someone else in the room helps …"

There are a variety of factors that can impact on the quality of sleep that an older person experiences. These factors can be internal (to the person) or external (mostly environmental). Many older people may complain about sleep issues such as:

- difficulty falling asleep
- frequent waking during the night, and lighter sleep
- waking up early and not feeling rested
- a desire to go to bed in early evening
- being tired in the daytime
- needing naps during the day

For many older people, disturbed sleep becomes a part of life, but many of these can be addressed by thinking about lifestyle and activity. Having an activity programme in place that involves a variety of activities both individual and group not just enhances the person's social connections but also impacts greatly on the person's quality of sleep. When a resident is requesting to go to bed early (before 6pm) [unless it has been their usual lifestyle pattern] then this can be an indicator of boredom, loneliness or dissatisfaction with the environment (e.g. too hot, too cold, too noisy and needs to be addressed through activities, social connection and environmental changes rather than sleep itself.

Paying attention to the environment is critical to the facilitation of sleep and ensuring that sleep is less fragmented. Adjusting lighting in the evenings, changing the pace of activities and reducing sensory stimulation are known to help with preparing for sleep and bringing the day to a close.

Reflective Activity

Have you ever thought about your sleep pattern? – when do you like to go to bed (usually)?; what time do you usually like to get up?; what are your settling down to sleep and getting up routines?; how does light/darkness, heat/cold, and sound effect your sleep pattern? What helps you to relax?

Freedom of Choice

Think about the residents in setting where you work. Do you know their settling down and waking up patterns? Have the residents in your care setting got a life-review document? Have the residents' families and friends contributed to its completion? Have you been able to establish insights into the residents' settling down and getting up patterns? Are there similarities between some of their patterns – if there are then this may help you work out how you can plan their care in a way that works best for those residents but also for you as a care team. For example, it might be the case that there are a number of residents who have a particular choice of drink before going to bed – these can be prepared together and the residents could drink them together to form a social gathering before they go to bed.

Consider how you plan for the settling of residents in the evening according to their routines. Start to plan for these in advance and agree as a team how you will work together to ensure that individual residents' choices can be met. Discuss with residents how these choices will be met and any issues that might prevent the choice being fully met and what compromises are needed.

Autonomy and independence

Consider ways in which the independence of residents can be maximised. For example, John-Joe (another resident in Bayview) rarely goes to bed before midnight. John-Joe has some evidence of memory loss but you know that he always likes to be 'busy'. In the evening John-Joe plays a significant role in helping the care team out. He washes up crockery after the evening meal, folds laundry and puts it in the store cupboard and he tidies the main lounge area. When ready and with some prompting, John-Joe will take himself to his bedroom where he sits listening to the radio until the care staff are ready to help him into bed.

Safety and Protection

When settling residents, it is important to consider issues of safety. Have you thought about ways to prepare their room or bed area to enable them to be safe and maximise independence? For example, it may be 'tempting' to raise bed-rails on a resident's bed in case the fall when you are busy with another resident – however, have you assessed the need for the bed-rails? Is there a greater risk from having bed-rails in place than not having them? Are you aware of the guidance on the use of bed-rails, see for example.

Whilst we will consider environment issues elsewhere, you need to think about these too in the context of safety. The use of lighting to help residents remain orientated in the night is important; having call bells ready to hand for residents; being conscious of those residents who might wander in the night and regularly attending to/observing them; planning aspects of work (such as record keeping) that can be done alongside residents who might be more anxious at night.

Safety issues are particularly important when residents are getting up as they may be more disorientated than at other times of the day. So for example, if a resident does use bed-rails, they may try to get out of bed whilst they are still raised; residents can get their feet caught in bed-sheets or trip over slippers and shoes on the floor. Remember too that for many residents their mobility may be reduced in the mornings so they may be less flexible and move more slowly.

The key point made is that you need to think about how you get to know the abilities of individual residents at different times of the day as their potential to be independent and remain safe can vary. Thus continuity of care giving and good care-team communication is important.

Social or Therapeutic Relationships

As identified earlier, helping older people to remain active is a key consideration in sleep and rest. Ensuring that residents have an individualised social programme that includes 'active' activities is important. Such activities can also have a therapeutic effect in terms of mobility, agility, flexibility, concentration, as well as enhanced sleep and rest. Do your residents have an individualised activity programme? Does the programme include a variety of activities that require different types of activity levels? Remember, just because the person has a disability, doesn't mean that they can't be active – consider discussing with team members the different ways that you can develop activities with your residents that maintain their activity levels.

Activities are also an opportunity for enhancing social relationships between residents and between you as care workers with residents. In doing the residents' life-review work, have you identified a range of activities that residents like to engage in? Consider how these activities can be used to enhance social relationships in the care setting. Have you thought about how you can involve family and friends in helping a resident get settled? For example, Phyllis struggles to settle at night as she has always slept with her husband prior to moving to the care home after her stroke. She gets upset going to bed and the care team think it is because she misses her husband. Twice weekly Phyllis' daughter takes her husband to visit later in the evening and he helps Phyllis to bed. He lies with her and holds her until she falls asleep. On these nights, Phyllis sleeps through the night and is so much more settled and contented.

Flexibility and Adaptability

Remember though that it is important to be flexible and adaptable – whilst you may know the particular times when a resident usually likes to go to bed and when they like to get up, there are always exceptions to these patterns. All of us occasionally like to stay in bed a bit longer than usual, so you need to be alert to that and to offer the resident options about the time to get up.

Privacy and Dignity

For most people, the bedroom is one of the most private and intimate spaces in a home. It holds memories of relaxation, sexual fulfilment, comfort, safety and personal space. For an older person moving to residential care this can be a huge change in their life. For others they may have reached a stage in their life where the privacy of the bedroom is less important to them and they place greater value on the company of others. Having options for completely privacy or shared space is important. How do you ensure that residents' bedrooms are kept private? Do you have a policy about asking permission to enter a resident's bedroom? (for example). How is the space in the bedroom respected in terms of taking care of the person's belongings, tidiness, cleanliness, comfort, smell etc?

The activities of settling down and getting up should also be attended to in a dignified way. For example, asking in a loud voice "who wants to go to bed next?" is not very dignified! Do you pay attention to dignity when getting residents dressed and undressed, ensuring complete privacy? Do you pay attention to the 'small but important details' – for example, many older women do not want to be seen by others without their hair sorted and their makeup put on, so do you know these things about your residents and how do you attend to these for those who are unable to express choice? Further, respecting the person's need for privacy, respect and dignity means that there should NEVER be a need for a resident to have parts of their bodies exposed unnecessarily and without their permission/consent.

Quality of Place and the Physical Environment

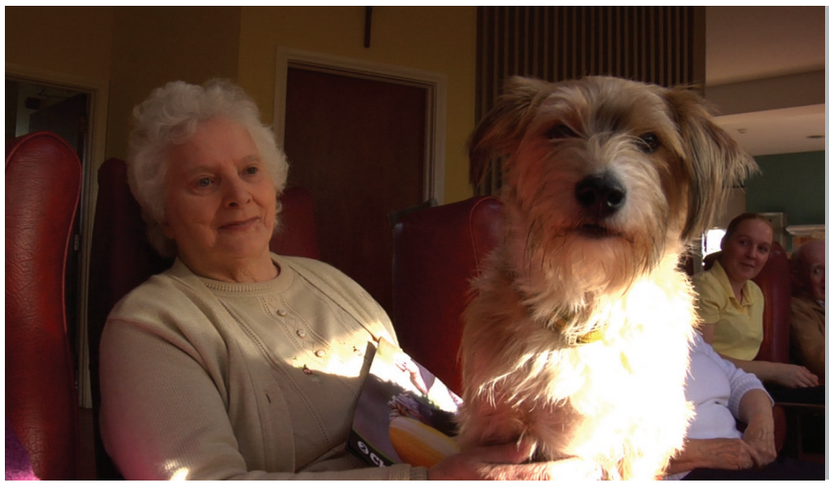
As identified earlier, evidence demonstrates that environmental factors have a significant impact on the quality of sleep and rest that an older person experiences. All of us have particular tolerance levels for light, heat, cold and sound and these levels of tolerance play a significant role in the quality of our sleep and rest. In the earlier reflective activity, did you identify particular issues associated with light, heat, cold and/or sound that effect the way you sleep? Do you know how these factors affect the residents' with whom you work? In addition, knowing how many pillows a resident likes to have, whether they have been used to a duvet or blankets/sheets and the kind of bed they have slept in are all important considerations. For example, getting used to sleeping in a single bed can be hard if you have only ever slept in a double bed – can invoke a fear of falling out of bed, for example.

Sensory Experience (light, colour sound, scent, taste, touch, feel, warmth / air)

Suggested areas for Place and Practice Improvement

In considering the patterns in the previous section, you may have identified some environmental aspects of the care setting that could be improved/changed as well as some aspects of practice. So you may want to consider these as some potential areas to address in order to enhance the experience of settling down and getting up for residents and the care team. These ideas are in no way exhaustive, but they may provide you with some options for consideration:

- implement a process for developing 'life review' with residents and their families and include aspects of 'sleep' in the review?
- Identify from life review documents residents' settling down and getting up patterns and adjust individual care plans to reflect these patterns.
- Set up a meeting with other care team members to discuss residents' individual settling down and getting up patterns and identify areas of similarity and difference. Consider ways in which you can adjust the way care and practice is organised to take account of these patterns.
- Do an assessment of the environment using the 'Workplace observations: walkabout guide' and identify adjustments that can be made to the environment that could enhance settling down and getting up activities.
- Undertake an observation of practice activity using the Workplace observations: guide' and focus specifically on a 'settling down' period for a group of residents.
- Undertake an observation of practice activity using the Workplace observations: guide' and focus specifically on a getting up' period for a group of residents.
- Present your findings from the observations of the settling down and getting up periods to the home managers/leaders and identify changes to the environment and practice that could be made.



References

Hughes CM., Roughead, E., and Kerse, N., (2000) Improving the Use of Medicines for Older People in Long-Term Care: Contrasting the Policy Approach of Four Countries, *Healthcare Policy* 3(3):37-51

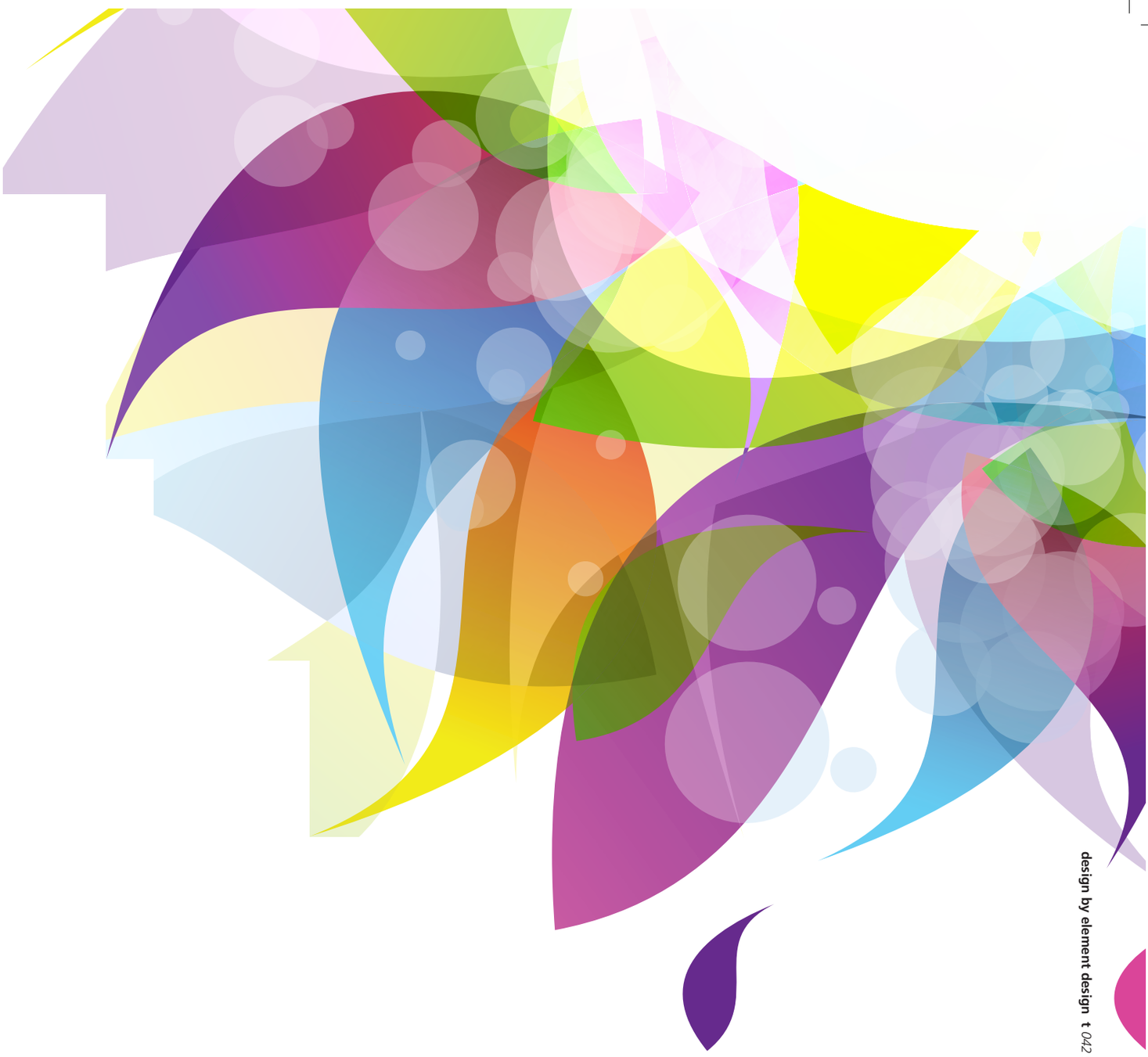
Kryger M, Roth T, Dement W (2000) *Principles & Practices of Sleep Medicine*. WB Saunders Company, Philadelphia

Siegel, J M. The REM Sleep-Memory Consolidation Hypothesis, *Science*, Vol 294, pp: 1058-1063

Additional Reading

Sleeping Well As You Age: Helpful Sleep Tips for Seniors
www.helpguide.org/life/sleep_aging.htm

Notes



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

DUNDALK
INSTITUTE OF TECHNOLOGY

University of ULSTER

The ATLANTIC Philanthropies

NHI nursinghomesireland

design by element design t 042 9327943