NHMRC Centre of Research Excellence to Optimise Sleep in Brain Ageing and Neurodegeneration (CogSleep CRE)

Semi-Structured Sleep-Wake Interview for Older Adults

Client name: ……..….

DOB: ……MRN: ……..

<u>Instructions</u>: The CogSleep Semi-Structured Interview is designed to be used in conjunction with training provided by the *Dementia Training Australia* (DTA) *Sleep Matters* course. Questions should ideally be asked of the patient/client but file notes, care staff, family and other health professionals may provide input, particularly if the client has cognitive impairment, dementia and/or communication difficulties.

PART 1: BACKGROUND INFORMATION (from file, or interview)

Age: ……	Gender ☐ Male ☐ Female	BMI: …….. Height: …… Weight: ……	
Cognitive or dementia diagnosis?	☐ No ☐ Yes	If yes, please specify: ☐ Mild cognitive impairment ☐ Vascular cognitive impairment ☐ Alzheimer's disease ☐ Dementia with Lewy Bodies ☐ Parkinson's Disease Dementia ☐ Frontotemporal dementia ☐ Stroke-related cognitive impairment ☐ Other, please specify: …….....	Cognitive screen scores if known: MMSE: …… MoCA: …… ACE-R: ……
Prior history of major depression	☐ No ☐ Yes	If yes, when was this? …… year If yes, was it treated with antidepressants? ….….. N/Y	
Assessment for current depression?	☐ No ☐ Yes	If yes, please provide details including score: ☐ Geriatric Depression Scale 15 item score = …… ☐ Cornell Scale for Depression in Dementia score = …… ☐ PHQ-9 score = …….. ☐ Other: …… score = ……..	
Relevant medical history:	Current Medications: ☐ Benzodiazepine ☐ Sedative hypnotic ☐ Melatonin ☐ Tricyclics	☐ SSRIs ☐ Steroids ☐ Other: ……	

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PART 2: SLEEP HISTORY		
1. Have you ever been diagnosed with insomnia?	☐ No ☐ Yes	If yes, How long did it last? ……. How was it treated? ……. Was the treatment successful? …… N/Y
2. Have you ever been diagnosed with obstructive sleep apnoea?	☐ No ☐ Yes	If yes, Was this diagnosed via a formal sleep study (PSG)? N/Y …… If yes, date if known: ……. What treatment was given (e.g. CPAP, dental splint)? ……. Was the treatment successful? ……. N/Y How long was it used? ……. Is it still being used? N/Y If no, how long have you stopped for? ……..
3. Have you ever been diagnosed with other sleep disorders?	☐ No ☐ Yes	If yes, please specify: Was this diagnosed via a formal sleep study (PSG)? N/Y …. If yes, date if known …… What treatment was given (e.g. CPAP, dental splint)? …… Was the treatment successful? ……. N/Y How long was it used? …… Is it still being used? N/Y
4. Have you ever received treatment for another sleep disorder?	☐ No ☐ Yes	If yes, please specify: ……
5. Have you used sleep medications in the past?	☐ No ☐ Yes	If yes, What medication was used? ……. Was the treatment successful? …… N/Y

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PART 3: NOCTURNAL SLEEP

6. Could you rate the quality of your sleep? (1 is best, 10 is worst)	1 2 3 4 5 6 7 8 9 10	☐ If the sleep quality rating is > 5, and the patient has difficulties getting to sleep, staying asleep, or waking early, and the patient has daytime sleepiness, the patient should be formally screened for insomnia. Suggested tool ***Insomnia Severity Index***.
SLEEP TIMING		**ACTIONS**
7. Over the last week, on average what time have you gone to bed at night?	Time: ……. pm	☐ Consider early bed-times may contribute to circadian disturbance, nocturnal awakening and late insomnia
8. Over the last week how long does it take you to get to sleep once in bed?	Time: …….. mins	If longer than 20 mins, are there distractions such as noise, lights, or other (e.g. residents, uncomfortable bedding). ☐ No ☐ Yes, specify……
9. What time do you get up in the morning?	Time: …….. am	☐ If needing to be woken every morning, consider impacts on night-time sleep quality including medications, napping, excessive time in bed, lack of exercise, initial insomnia, depression, light, other disruptions.
10. Do you wake up during the night?	☐ No ☐ Sometimes (at least 3 nights per week) ☐ Yes	If yes or sometimes, a) How many times? …… b) How long would you be awake for typically? …… c) Do you primarily wake to use the bathroom? N/Y d) Do you wake up with pain? N/Y e) What do you do once you wake up? ☐ Stay in bed

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		☐ Turn lights on ☐ Watch TV ☐ Use phone or computer ☐ Other, please specify: …… f) What do you do to try and get back to sleep? …….. g) Are there any instances of night-time wondering/confusion? N/Y
11. Do you feel refreshed in the morning after sleep?	☐ No ☐ Sometimes (at least 3 nights per week) ☐ Yes	☐ Consider impacts on night-time sleep including sleep apnoea, benzodiazepine or sedative hypnotic medications, napping, insomnia, depression, light, other disruptions.
12. Do you think you are getting enough sleep?	☐ No ☐ Sometimes (at least 3 nights per week) ☐ Yes	
SLEEP APNOEA (NOTE: If interviewee already has a diagnosis of sleep apnoea, proceed to Question 15)		**ACTIONS**
13. Do you snore or have family or caregivers ever told you that you snore?	☐ No ☐ Yes	☐ Consider sleep apnoea questionnaire including ***STOP-BANG***, overnight oximetry or consider discussion with GP regarding polysomnography.
14. Has anyone ever noticed that you gasp for air or stop breathing while you sleep?	☐ No ☐ Yes	
DAYTIME FUNCTIONING		**ACTIONS**
15. Do you sleep in the daytime?	☐ No ☐ Yes	If yes, a) How many times a week? ……. b) How many times per day? …… c) What time? ….. d) If in morning, for how long? ……... mins e) If after lunch, for how long? …..…. mins f) If early evening, for how long? ….. mins ☐ Consider impacts of daytime napping on night-time sleep quality including ability to fall asleep, length of sleep, timing of sleep, and depth of sleep.
16. Are you really sleepy and tired during the daytime?	☐ No ☐ Yes	If yes, are you finding that you are falling asleep at times or during activities when you shouldn't ☐ In the morning ☐ In the early evening ☐ During meals ☐ During conversations ☐ Consider activities, medical conditions and medications causing daytime sleepiness, such as light levels, inactivity, meals or poor night-time sleep quality.

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		☐ Sitting and watching TV ☐ When reading ☐ During social or recreational activities ☐ After lunch Does this happen ☐ Rarely ☐ 1-2 / week ☐ 3+ ☐ everyday	
17. Do you get restless/irritable/agitated in the afternoon/early evening	☐ No ☐ Yes		
REM SLEEP BEHAVIOUR DISORDER			
18. Have you ever been told or suspected yourself that you seem to act out your dreams while asleep? (for example, punching, kicking, knocking down furniture, running movements).	☐ No ☐ Yes		☐ If yes, suggested tool ***REM Sleep Behaviour Disorder questionnaire***. ☐ If yes, review with GP – clonazepam may be helpful and modification of environment for safety.
RESTLESS LEGS SYNDROME			
19. When you try to relax in the evening or sleep at night do you ever have unpleasant restless feelings in your legs that can be relieved by walking or movement?	☐ No ☐ Yes	If yes, a) Is there an urge to move legs, with uncomfortable or unpleasant sensations? b) Do the feelings begin or worsen during periods of rest or inactivity? c) Are the feelings partially or totally relieved by movement? d) Are the feelings worse in evening or night, compared to night?	☐ If yes, consider using the ***International Restless Legs Syndrome Rating Scale*** (Walter AS, Sleep Med 2013) and, also consider restless legs causing medications and other medical conditions (e.g. venous statis, oedema, other factors such as arthritis).
MEDICATION AND ENVIRONMENTAL FACTORS			**ACTIONS**
20. Are you taking sleeping medications?	☐ No ☐ Yes	If yes, which ones: …….	☐ If yes, benzodiazepines, antipsychotics, and sedative hypnotics should only be used for up to 2 weeks. Review with GP and consider melatonin.

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21. Are you taking a combination of more than 5 medications?	☐ No ☐ Yes	If yes, have you had your medication reviewed by a pharmacist? N/Y	☐ Consider pharmacy or GP medication review.
22. Has there been a recent change in residential environment?	☐ No ☐ Yes	If yes, when? ……	
23. Do you share the room environment with other house or residential facility members	☐ No ☐ Yes	If yes, how many? ……	☐ Consider noise/disruptions/comfort.
24. Are you exposed to natural light during the daytime?	☐ No ☐ Yes	If yes, when: ☐ Early morning 2-3 hours after waking, for how long …….. mins ☐ Mid-morning to lunch, for how long …… mins ☐ After lunch to early afternoon, for how long …….. mins ☐ Early afternoon to early sunset, for how long …….. mins If no, do you get a dose of strong (greater than normal house lights, e.g. > 100 watt) light at any stage throughout the day? If no, does your residence have any built circadian lighting (e.g. blue light enriched) How long on average? …….. hours/day	☐ Consider bright light exposure in morning and daytime. ☐ Consider dimming lights in evening, including screens.
25. Do you engage in exercise/physical activity?	☐ No ☐ Yes	Specify: ……	☐ Consider daytime physical activity.
26. Do you engage in cognitive activity?	☐ No ☐ Yes	Specify: ……	☐ Consider active cognitive engagement activity (not passive activity such as TV).

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27. What time do you have meals/snacks?		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Night eating?	☐ Consider sedating foods around lunchtime (e.g. pasta, carbohydrates, alcohol), and dinner foods that interfere with melatonin or are alerting (e.g. bananas, tomatoes, turkey, chocolate).
28. Caffeine/alcohol	☐ No ☐ Yes	☐ Caffeine, times: …….. units/day: …….. ☐ Alcohol, times: …… units/day: ……	☐ Consider limiting caffeine from 4pm. ☐ Consider limiting daytime alcohol and excessive evening alcohol.
29. Is your sleep at night affected by noise or light?	☐ No ☐ Yes	Specify: ……	☐ Consider location of room, and whether nearby lights can be censored or dimmed, earplugs.
30. Night-time fluid	☐ No ☐ Yes	If yes, does your night-time fluid prevent you from falling asleep and wake you during the night or early morning?	☐ Consider reducing evening fluids/other medications for incontinence?
31. Do you have pain at night?	☐ No ☐ Yes	If yes, does your pain prevent you from falling asleep and wake you during the night or early morning? ……	☐ Consider ***Brief Chronic Pain scale*** and DTA pain module.
32. Tell me about your mood?	Rate on scale from 1 to 10: …….. (1 = very low mood, 10 = best)	☐ Lack of interest or pleasure in usual activities? ☐ Low mood, sad, hopeless? ☐ Poor appetite ☐ Low energy levels ☐ Withdrawn from social activities ☐ Somatic symptoms ☐ Feeling worthless ☐ Thoughts of death, suicide	☐ If rating < 6 or cardinal depression symptoms for at least two weeks, consider, ***Geriatric Depression Scale 15 item*** score = …….. (scores ≥ 6 may be suggestive of depression).
33. Do you have any worries or concerns that are on your mind that stop you from sleeping?	Rate on scale from 1 to 10: …….. (10 = no concerns, 1 = nightly worry impacting sleep)		☐ If rating < 6, explore stress, anxiety and other factors and need for relaxation strategies prior to bedtime.

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