Documentation During Sleep Studies

Audience: All personnel in the Sleep Disorder Center.

Purpose: Documentation of patient activities at regular intervals throughout the study assists in the appropriate scoring and interpretation of the sleep study. The technician’s written descriptions of patient behavior during the study are essential for appropriate interpretation and diagnosis.

Policy: Patient Documentation (Pre & Post Evaluation Questionnaires)
- Once a sleep study has been scheduled, the patient is mailed an information packet which includes the following for their completion:
  o Demographic and medical information
  o Epworth Sleepiness Scale
  o Patient sleep survey
- At the end of the sleep study, the patient will be given a Post Evaluation Survey

Sleep Technologist Documentation:
- Prior to beginning the sleep study, the sleep technologist must have a signed Consent for a Sleep Study from the patient
- Technical documentation includes the polysomnogram generated report with PAP pressures (if indicated) either recorded manually on the record or automatically recorded by a signal from the PAP device. Technical documentation includes a technologist generated log of all events, observations, and interventions that occurred during the sleep study. The sleep technologist will record the following information:
  o Sleep Disorder Flowsheet (documented every 15 minutes)
    ▪ Time
    ▪ Stage
    ▪ Position
    ▪ SpO2
    ▪ Snore
    ▪ CPAP
    ▪ Leak
    ▪ O2
    ▪ Comments
  o Polysomnogram Technical Report (completed at the end of the study)
    ▪ EEG
    ▪ Snoring
    ▪ EKG
    ▪ Apneas/hypopneas
    ▪ Desaturations
    ▪ Worse Event Position
Leg Movements
Patient Tolerance
Patient Feedback
CPAP/BiPAP
Study #
Room Number
Notes (the technologist should include a summary narrative of the nights events in this section of the report)

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