HACKETTSTOWN REGIONAL MEDICAL CENTER
CENTER FOR SLEEP RELATED DISORDERS
DOCUMENTATION DURING SLEEP STUDIES

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PURPOSE:

Documentation of patient activities at regular intervals throughout the study assists in the scoring and appropriate interpretation of the sleep study. The technicians' written descriptions of visual and auditory behavior or relevant patient interactions which are not recorded during the sleep study or which elaborate on associated events seen in the polysomnographic recording are essential for appropriate interpretation and diagnosis.

POLICY:

All Sleep Technicians/Technologists are required to chart in the Technician study log every 30 minutes during the acquisition of a study. Data should contain short summaries of the last 30 minutes observed (i.e. position changes, cardiac arrhythmia's, respiratory events). In addition to standard 30 minute charting, techs should chart any pertinent changes in patient status as they appear and changes in patient treatment (i.e. CPAP/Bi-Level changes) in the study log.

Technicians/Technologists are also required to fill out patient details and service details with a complete summary of the study (documenting such things as Epworth, patient health hx, treatment, tolerance to treatment, equipment used, and any other relevant information used for diagnosis).

PROCEDURE:

- Techs should document in the study log every 30 minutes
- Study log entries should contain a brief summary of events during the last 30 minutes.
- Additional entries in the study log should be made for changes in patient status, treatment information, etc.
- Summary of the study will be housed in the service details section of the patient demographics.
- CPAP information will be housed in service details under the Equipment tab.
- All Technologists are required to fill out the appropriate physician information