

**Insomnia Risk Plan**

**Participant’s Name:**

**Date plan begins:**

**Date Plan expires:**

**Dates of Revisions:**

**Written by:**

**Risk:**       is at risk of experiencing symptoms of insomnia.

**Desired Outcome:**       will maintain a lifestyle that promotes a healthy sleep routine. Staff will respond as trained if symptoms of insomnia are exhibited.

**Why at risk/History:**

**Insomnia** is repeated difficulty with sleep initiation, maintenance, consolidation, or quality that occurs despite adequate time and opportunity for sleep and results in some form of daytime impairment. The condition can be short-term (acute), lasting from 1 night to a few weeks, or can last a long time (chronic), lasting at least 3 nights a week for 3 months or more. It may also come and go. Common causes are poor sleep habits, depression, anxiety, stress, change in schedule or routine, poor dietary habits, mental or medical conditions, lack of exercise, chronic illness, or certain medications.

**Supports and interventions:**

* Staff will encourage regular exercise.
* Staff will encourage      , as needed, to maintain a regular, relaxing nightly routine.
* Staff will encourage      , as needed, **to avoid napping throughout the day**.
* Staff will encourage      , as needed, to avoid eating heavy meals or foods that may cause acid reflux or indigestion before bedtime.
* Staff will encourage      , as needed, to **avoid caffeine**, nicotine, and alcohol late in the day.
* When preparing for bed, consider temperature, noise level, light sources, and other environmental factors.

**Monitor:**

* Difficulty falling asleep at night
* Waking up during the night
* Waking up too early
* Not feeling well-rested after a night's sleep
* Daytime tiredness or sleepiness
* Irritability, depression or anxiety
* Difficulty paying attention, focusing on tasks or remembering
* Increased errors or accidents
* Ongoing worries about sleep
* Lack of energy

**Notify:**

* **Call 911 if emergency intervention was necessary, such as, back blows, abdominal thrusts, CPR, etc., exhibiting multiple or severe symptoms, if more than first aid is needed for injuries, if they hit their head, any type of reaction that interferes with the ability to breathe or swallow, rapidly worsening symptoms, or loss of consciousness.**
* Notify Program Manager, Health and Safety Tech and/or Nurse of any symptoms of insomnia, change of condition, or concerns.
* Program Manager will notify family, guardian, other Program Managers, and/or Providers of any symptoms of insomnia, change of condition, or concerns.
* Staff will document on incident report by end of shift.

**If 911 is called:**

* Remain with       until EMTs arrive. If emergency intervention was necessary, continue as trained until relieved by EMTs.
* Ensure that emergency personnel are aware of all medical conditions, allergies, and medications.
* Follow       to the hospital and remain with participant until relieved by staff or family.
* Complete an incident report by end of shift and BDDS report within 24 hours.

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| **Provider** |  | **Risk Plan** |  |  | **Date Effective** |
| **Paladin** | | **Insomnia** | | |  |
| **Print Name** | | **Signature** | **Company/Title** | | **Date** |
|  | |  | **Paladin/Program Manager** | |  |
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