Sleep in PALTC: What's Changed, What Matters, What to Do

Sleep matters. In post-acute/long-term care (PALTC), it affects cognition and memory, and influences mood and behavior. It also affects rehab participation, fall risk, cardiovascular health, rehospitalizations, and staff workload. At a PALTmed annual meeting session, *Sleep in PALTC: What's Changed, What Matters, What to Do*, Matt Griffith, MD, MPH, of the University of Colorado Anschutz, offered some key insights into how to manage sleep in older adults:

- ✓ That older adults need less sleep is a myth. In truth, said Griffith, this population still needs at least seven hours of sleep daily, though their sleep is lighter, less efficient, and more fragmented. They experience more awakenings and less deep sleep.
- ✓ Sleep disruptions in PALTC setting include med pass times that wake residents up at night or early in the morning, excessive noise, light exposure, shared rooms with people who have different habits, lack of familiar environmental cues, and incontinence/nocturia.
- ✓ Obstructive sleep apnea (OSA) may be undiagnosed, and less obvious clues may be missed or attributed to other issues. These clues include sleep-onset insomnia, resistant hypertension, cardiac symptoms (e.g., atrial fibrillation or worsened heart failure), anxiety, and depression.
- ✓ Finger-worn and disposable sleep apnea testing devices are now common with remote or telehealth prescribing and interpretation. Nocturnal oximetry cannot qualify a patient for a CPAP device.
- ✓ In PALTC, sleep apnea treatment decreases fall risk, daytime sleepiness, anxiety, and depression. It improves cognitive function and decreases mortality.
- ✓ Research suggests a potential correlation between circadian rhythm disruption and dementia. Dementia can lead to irregular sleep-wake rhythm disorder and unstable day-night sleep patterns. This can result in increased wandering at night, increased fall risk, and sundowning. Evidence-based interventions include bright morning light, structured daytime activity, and reduced evening activity.
- ✓ REM sleep behavior disorders are common among individuals with Parkinson's disease, Lewy Body dementia, or multiple system atrophy. This may mean dream enactment, punching, kicking, or falling from the bed.

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Start with Sleep Screening

Griffith stressed that before adding a sleep medication, it is essential to determine what is disrupting sleep in the first place. For instance, Griffith identified medications that are common contributors to sleep disruption. These include diuretics, oral corticosteroids, beta blockers, SSRIs, and donepezil. At the same time, taking multiple medications (polypharmacy) can disrupt sleep through direct side effects caused by drug interactions, and stimulation of the central nervous system. Also consider other factors that can cause sleep disruptions:

- ✓ **Medication timing.** Does the nurse have to wake up a resident in the morning or at night to administer a medication? Can the timing be changed to align with the person's habits and preferences?
- ✓ **Daily routine.** Does the resident have a regular routine? Do they practice good sleep hygiene? Do they consume alcohol and/or caffeine?
- ✓ **Environmental disruptions.** Is the resident's room dark and quiet at night? Are staff going in and out of the room when the resident is sleeping?
- ✓ **Physiologic issues.** Does the resident have unaddressed pain, incontinence, or other issues that might be disrupting their sleep?

Griffith suggested starting with a four-question sleep screening:

1. Does the resident snore, stop breathing, or have excessive daytime sleepiness?
2. Does the resident have difficulty falling asleep, staying asleep, or waking too early?
3. Is the resident awake or asleep at the wrong time of day?
4. Does the resident act out dreams or show unusual movements during sleep?

He offered a five-week 'to do' list:

Five-Week Sleep Screening To-Do List

Week 1: Implement sleep screening questions

Week 2: Identify patients on sleep aides

Week 3: Begin deprescribing or switching if necessary

Week 4: Implement morning light exposure

Week 5: Identify untreated insomnia

Throughout: Track nighttime falls, sedative use, and CPAP adherence (as appropriate)

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Try Non-Pharmacologic Interventions

"Non-pharmacologic approaches are more effective, sustainable, and less harmful than any sleep medication," Griffith said, so addressing the above issues is a strong starting point. Elsewhere, Cognitive Behavioral Therapy for Insomnia (CBT-I) is the gold standard to address sleep issues. This is a short, structured, evidence-based approach in which a trained professional helps the individual identify thoughts, feelings, and behaviors that are contributing to their sleep problems. In PALTC, interventions might include promoting a consistent sleep/wake schedule, ensuring morning light exposure, avoiding sedating medications, and getting the individual out of bed and active during the day.

However, there are barriers to CBT-I in PALTC. These include limited access to trained therapists, cognitive impairment, and low patient participation. Griffith identified the CBT-I Coach app from the Department of Veterans Affairs as a useful tool. According to the VA, this "guides users through the process of learning about sleep, developing positive sleep routines, and improving their sleep environments. It provides a structured program that teaches strategies proven to improve sleep and help alleviate symptoms of insomnia."

Light therapy also has shown to be effective. Studies involving older adults and those with Alzheimer's disease have demonstrated improvements in subjective sleep quality, circadian rhythm stability, sleep latency, sleep efficiency, and cognitive function.

Choose Appropriate Medications if Needed

If non-pharmacologic interventions are unsuccessful, short-term pharmacologic therapy may be appropriate. According to the American Geriatrics Society (AGS), medications that may be safer (but not completely safe) and have evidence of benefit in older adults include low dose doxepin (up to 6mg) as noted in their Alternate Treatments to Selected Medications in the 2023 AGS Beers Criteria® guideline, published in 2025.

Ramelteon and melatonin both stimulate melatonin receptors (MT1 and MT2) in the brain, helping to regulate the sleep-wake cycle. The main difference is that ramelteon is a synthetic melatonin receptor agonist, while melatonin is a hormone. There is more compelling evidence for ramelteon, Griffiths said, and trials have shown consistent improvement in sleep latency compared with placebo. The recommended dose is 8 mg, 30 minutes before bedtime, as needed. The AGS notes there is insufficient evidence to recommend melatonin. It is primarily effective for treating circadian rhythm disturbances, rather than insomnia.

Dual orexin receptor antagonists (DORA) are a new class of medications designed to address insomnia by blocking the action of the neurotransmitter orexin. The drugs act by decreasing wakefulness rather than increasing somnolence.

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> **- Matt Griffith, MD, MPH, University of Colorado Anschutz**

Medications to avoid include benzodiazepines, Z drugs (medications that interact with the benzodiazepine GABA receptor complex to promote sleep), first generation antihistamines, tricyclic antidepressants, and barbiturates.

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As in so many areas, Griffith said, deprescribing is worth the effort to help address sleep issues in older adults. This can help prevent falls and fall-related injuries, decrease patient harm, and improve peoples' overall wellbeing and quality of life.

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