

Ward Noise, Sleep Disruption, and Night-Time Nursing Care in Inpatient Palliative Settings

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Abstract

Sleep disruption in inpatient palliative settings reflects the interaction of symptoms, patient vulnerability, ward conditions, clinical surveillance, medication, alarms, equipment, and unpredictable care. This conceptual article proposes a night-time nursing framework based on three judgments: susceptibility to disturbance, cumulative nocturnal burden, and the necessity and modifiability of each interruption. It distinguishes care that is immediately necessary, care that is required overnight but can be coordinated, and disturbance that can be reduced without compromising safety. Nursing may therefore fragment or protect sleep according to timing, coordination, symptom responsiveness, and patient priorities. Sleep protection should intensify when vulnerability and modifiable disturbance are high while preserving clinically necessary surveillance and symptom relief.

Keywords: Palliative care, Sleep disruption, Ward noise, Night nursing, Sleep fragmentation, Inpatient care

Introduction

Sleep disturbance is increasingly recognized as a clinically relevant problem in advanced cancer and specialist palliative care. Available evidence links disturbed sleep with physical and psychological morbidity, while also showing that sleep problems may remain under-recognized amid more immediately visible symptoms and treatment demands [1, 2]. In an inpatient palliative setting, however, poor sleep is rarely attributable to one source. Hospitalized patients encounter unfamiliar surroundings, illness-related discomfort, environmental noise, staff activity, monitoring, medication administration, observations, and variable opportunities for uninterrupted sleep. Nursing interventions may either reduce or add to this burden, depending on how care is organized and individualized [3, 4].

The analysis treats the nocturnal period as a configuration in which the significance of disturbance depends on patient vulnerability, cumulative burden, timing, and whether an event is necessary, reschedulable, attenuable, or avoidable. It rejects both the assumption that every awakening is inappropriate and the assumption that routine care is exempt from sleep-protection scrutiny. The objective is to strengthen rest without weakening symptom relief, monitoring, or safety.

Conceptual approach

The appropriate unit of analysis is the night-level care configuration rather than the isolated noise event. Contemporary hospital sleep guidance increasingly treats sleep as a legitimate component of inpatient care while acknowledging that clinical needs constrain uninterrupted rest [5]. Institutional practice nevertheless varies

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considerably, indicating that sleep protection is shaped not only by patient pathology but also by organizational routines, professional expectations, environmental design, and the defaults embedded in hospital workflow [6].

Sleep as a palliative care need

Sleep has a distinctive place in palliative care because the value of rest is inseparable from comfort, symptom burden, psychological well-being, and the patient's own priorities [7]. International palliative-care sleep work has emphasized that generic sleep advice may be inadequate when disease complexity, treatment burden, developmental or functional needs, and family or professional care requirements shape the sleep environment [8]. Although some consensus evidence arises from pediatric palliative care, the broader implication is relevant: sleep assessment in serious illness must be integrated with the conditions that make sleep difficult and with the reasons that care continues overnight.

Advanced-cancer intervention research also demonstrates that sleep remains modifiable even in the context of serious illness. Combined behavioral approaches have produced improvements in selected objective and subjective sleep outcomes in patients with advanced cancer, including measures related to insomnia and nocturnal awakening [9]. These findings do not establish that behavioral intervention can overcome the full burden of inpatient palliative disruption, but they challenge therapeutic pessimism. Sleep problems should not be assumed to be an unavoidable consequence of advanced disease.

Table 1 follows this section and differentiates the analytic domains that must remain separate when night-time sleep protection is considered.

Table 1. Distinguishing the domains that determine sleep protection during inpatient palliative care

Analytic domain	Primary question	What the domain captures	What it should not be conflated with	Immediate implication for night care
Sleep as a palliative need	How important is protected rest for this patient now?	Comfort, restoration, personal preference, perceived sleep quality and tolerance of interruption	A universal requirement for maximal uninterrupted sleep	Establish patient-specific sleep priority
Sleep-regulatory substrate	What biological processes make sleep possible or fragile?	Homeostatic sleep pressure, circadian timing and cancer/treatment-related regulatory disruption	The ward environment itself	Recognize that identical environments can produce different sleep outcomes
Patient-level vulnerability	How costly is an interruption likely to be on this night?	Disease burden, frailty, arousal tendency, cognitive state, functional reserve and ability to return to sleep	Symptom severity alone	Increase protection when recovery from awakening is difficult
Symptom-driven disruption	Which internal experiences are actively preventing or interrupting sleep?	Pain, dyspnea, anxiety and other symptom-related arousal	Environmental noise	Prioritize symptom relief before assuming environmental modification is sufficient
Environmental disturbance	Which external conditions reduce sleep opportunity?	Ambient sound, lighting, physical ward conditions and shared-space disturbance	Clinically necessary bedside care	Modify exposure where feasible without compromising observation
Care-generated interruption	Which aspects of professional work create awakenings or arousal?	Alarms, equipment, observations, medication, procedures and staff activity	Unnecessary disturbance by definition	Classify each interruption by necessity and timing flexibility
Sleep-protection decision	What should be retained, reorganized, attenuated or removed?	Integration of patient vulnerability, cumulative disturbance and clinical necessity	A fixed quiet-time protocol	Match protection strategy to patient state and care requirement

Note: The domains interact during a single night; the framework does not imply fixed thresholds or universal priorities.

Circadian and sleep-regulation foundations

Sleep disturbance in serious illness cannot be understood only as a response to noise. Cancer and its treatments are associated with a range of sleep disorders and sleep-wake disturbances, and the relationship is clinically heterogeneous rather than reducible to a single pathway [10]. Sleep timing and quality also intersect with circadian, endocrine, neurological, metabolic, and behavioral processes that may already be dysregulated in cancer [11, 12]. Consequently, environmental or clinical interruptions occur against a biological substrate whose capacity to initiate, maintain, and restore sleep may already be compromised.

Circadian timing is particularly relevant to inpatient care because exposure to light, darkness, activity, feeding, medication, and social routines contributes to temporal organization. When daytime light is limited, nighttime lighting is excessive, or activity is distributed irregularly across the 24-hour period, sleep-wake timing may become less coherent. Evidence from combined bright-light and melatonin interventions demonstrates that circadian timing can be modified under some conditions, although sleep benefits vary by population, intervention timing, and underlying disorder [10, 11, 13]. This variability is important for palliative care: a biologically plausible sleep intervention should not be assumed to be clinically useful for every seriously ill inpatient.

Patient-level vulnerability

The burden of a nocturnal disturbance depends on the patient who experiences it. Advanced illness may reduce physiological reserve, increase symptom sensitivity, alter mobility, increase dependence on staff, and complicate the transition back to sleep after awakening. Feasibility work in advanced cancer suggests that sleep and energy problems can be approached through multimodal intervention rather than treated as fixed consequences of disease [14]. At the same time, such work underscores the importance of adapting interventions to what seriously ill patients can realistically undertake.

Pain, dyspnea, anxiety, and other symptoms

Symptoms are not simply competing explanations for poor sleep; they are active components of the nocturnal configuration. Pain may delay sleep onset or provoke awakening. Dyspnea can produce repeated arousal, positional changes, oxygen-related equipment use, or requests for reassurance. Anxiety may amplify attention to bodily sensations and environmental sound, while poor sleep itself may increase distress and reduce tolerance of subsequent discomfort. The advanced-cancer literature supports clinically relevant associations between sleep disturbance and physical and psychological morbidity, but the direction and magnitude of these relationships vary [1].

Pharmacological treatment of insomnia in advanced cancer also remains evidence-limited. A palliative-care scoping review found a heterogeneous pharmacological literature insufficient to support simple class-wide conclusions [15]. This matters because the night-time response to sleep difficulty can easily become medication-centered even when disturbance is being maintained by symptoms, ward activity, fear, or repeated observations. Non-pharmacological evidence in advanced cancer is similarly developing rather than definitive. Available studies include behavioral and supportive approaches, but the evidence base remains small and heterogeneous [16]. The appropriate interpretation is neither that medication should be avoided nor that behavioral intervention is always preferable. The more defensible principle is diagnostic: identify what is keeping this patient awake before selecting the response.

Environmental noise

Environmental noise is one of the most visible and potentially modifiable causes of disturbed inpatient sleep. Contemporary synthesis has linked inpatient noise exposure with sleep and other patient-relevant outcomes, while also documenting substantial variation in how noise is measured and how outcomes are assessed [17]. In palliative wards, sources may include corridors, doors, bins, carts, staff conversation, ventilation systems, telephones, alarms, equipment and activity around neighboring patients.

Noise-reduction interventions in intensive care demonstrate that objective acoustic exposure can be modified, but associated clinical and perceptual outcomes are heterogeneous [18]. ICU findings cannot be transferred uncritically to inpatient palliative units, where acuity, monitoring needs, room design and patient priorities differ. They nevertheless establish an important boundary: environmental sound is not an immutable feature of hospital care. The question is which sound can be reduced without concealing clinically necessary signals or obstructing communication.

Alarms, equipment, and ward activity

Alarms, equipment and ward activity occupy a different analytical category from ambient environmental noise because they arise from the organization and technology of care. Human-centered ward redesign has shown that perceived restfulness can be addressed through combined environmental and workflow changes rather than through acoustic treatment alone [19]. This distinction is important in palliative settings, where equipment may be essential for oxygen delivery, infusion, monitoring, pressure relief, secretion management or other patient-specific needs.

Care activity also fragments the opportunity for sleep even when it is not especially loud. Electronic-record analyses of older hospitalized adults demonstrate that observations and other clinical activities occur during normal sleep periods and interrupt otherwise uninterrupted intervals [20]. The relevant exposure is therefore not solely decibels; it is the entry, light exposure, touch, conversation, repositioning, cuff inflation, device manipulation and cognitive arousal associated with the task.

Other patients and visitors

The social environment of the ward can influence sleep through conversation, movement, shared lighting, television, distress, care delivered to neighboring patients and visitor activity. Yet this source should not be exaggerated. Ward intervention research has shown that sleep determinants are multidimensional and that room occupancy itself does not necessarily explain observed sleep quality [21]. This null finding is analytically useful because it warns against treating shared accommodation as a sufficient explanation for poor sleep.

Night-time nursing interventions

Nursing work occupies a dual position: it can fragment sleep, and it can create the conditions in which sleep becomes possible. Sleep-promoting bundles used in critical care illustrate how environmental modification, care coordination and bedside practice can be organized around sleep while preserving clinical surveillance [22]. Their transfer to palliative care requires caution, but the implementation principle is relevant: sleep protection becomes more reliable when it is embedded in routine work rather than left to individual discretion.

Nursing interventions may include symptom assessment, repositioning, toileting support, mouth care, medication, reassurance, environmental adjustment, clustering of compatible tasks, reduction of avoidable light and noise, or facilitation of preferred sleep routines. Some strategies, including eye masks, earplugs and relaxation-oriented interventions, have favorable evidence in postoperative populations, although effects vary and tolerability matters [23]. Such measures are options rather than default bundle components. Earplugs may be unacceptable to a patient who fears missing staff; an eye mask may increase disorientation; relaxation exercises may be burdensome during severe breathlessness.

Medication and observation schedules

Scheduled medication and clinical observations deserve separate analysis because they often occupy a gray zone between necessity and modifiability. Pharmacological evidence for inpatient insomnia is heterogeneous, and medically fragile or complex populations are not equally represented across comparative trials [24]. In palliative care, sedative effects, interactions, delirium risk, respiratory status, prior exposure and goals of care further complicate any assumption that night-time wakefulness should automatically trigger additional medication.

The timing of routine tasks is a different problem. Sleep-friendly hospital initiatives have shown that electronic defaults, vital-sign schedules and overnight room entry can be modified, with reductions in selected night-time disruptions when patients are clinically appropriate for less intrusive schedules [25]. The transferable principle is not that observations should be omitted. It is that the timing and frequency of routine care should be justified rather than inherited from default practice.

Table 2 summarizes how common forms of nocturnal clinical activity can occupy different positions between safety necessity and sleep-protection opportunity.

Table 2. Night-time clinical work as a sleep-disturbance and safety-responsibility field

Nocturnal activity	Immediate clinical purpose	Principal sleep-disruption mechanism	Potential necessity state	Modifiability lever	Safety condition for modification
Alarm response	Detect equipment, physiological or treatment-related change	Sound, light, staff entry, conversation, repeated arousal	May be immediately necessary	Alarm parameter review, prompt response, reduction of non-actionable burden	Clinically meaningful alarms remain detectable and actionable
Essential equipment use	Deliver therapy or support monitoring	Continuous/intermittent noise, vibration, manipulation	Often necessary	Placement, maintenance, low-noise operation where feasible	Therapeutic function must be preserved
Routine observations	Assess physiological stability	Entry, light, touch, cuff inflation, conversation	Necessary at variable frequencies	Patient-specific frequency and timing; clustering	Reduced frequency only when clinically appropriate
Scheduled medication	Maintain treatment or symptom control	Awakening, assessment, administration activity	Time-critical or timing-flexible depending on treatment	Review administration timing and clustering	Pharmacological efficacy and symptom control preserved
Unscheduled symptom care	Relieve pain, dyspnea, anxiety or other distress	Awakening and bedside intervention	Usually immediately necessary when distress is active	Efficient assessment and coordinated treatment	Relief of suffering takes precedence over sleep continuity

Staff communication and movement	Coordinate safe care	Speech, footsteps, doors, light and nearby activity	Necessary communication, modifiable transmission	Location, volume, workflow and environmental design	Communication quality and escalation pathways preserved
Multiple compatible bedside tasks	Complete several required care activities	Repeated separate awakenings if uncoordinated	Tasks may individually be necessary	Care clustering and shared timing plan	Clustering must not delay time-sensitive intervention

Note: Necessity is patient- and time-dependent. No category is permanently “avoidable” or “mandatory”; clinical condition and goals of care determine the appropriate classification.

Interaction between noise, symptoms, and care interruptions

Disturbances accumulate and interact. Changing the schedule of selected tasks can reduce preventable interruption [26]. If dyspnea awakens a patient shortly before a routine observation, combining clinically compatible care may prevent a second awakening; separating tasks, followed by an alarm or corridor activity, may prolong wakefulness. Effective intervention therefore targets the dominant configuration rather than a single minor noise source.

Consequences of sleep fragmentation

The clinical relevance of sleep disturbance in advanced cancer is supported by its association with physical symptoms, psychological burden and impaired quality of life [1]. Hospital research also shows that patients commonly experience poorer sleep during admission than in their usual environment [3]. These findings justify clinical attention without establishing that every adverse outcome observed in hospitalized populations is caused by fragmented sleep.

Safety versus sleep protection

The tension between safety and sleep protection is often presented as though clinicians must choose one. A more useful distinction is between necessary interruption and unexamined interruption. Hospital sleep guidance recognizes that sleep-promoting practice must coexist with the requirements of safe clinical care [5]. Objective evidence that observations and other clinical tasks interrupt sleep should therefore trigger review of timing and indication, not automatic removal [20].

Three states are clinically useful. First, some care is necessary now: treatment of severe pain or dyspnea, response to deterioration, urgent reassessment, a time-critical medication, or action on a meaningful alarm. Sleep protection does not override these tasks. Second, some care is necessary during the night but timing-flexible: compatible assessments or treatments may sometimes be clustered to preserve a longer uninterrupted interval. Third, some disturbance is modifiable without reducing necessary care, including avoidable noise, unnecessary room entry, poorly located staff conversation, preventable alarm burden or default task timing that lacks a patient-specific indication. Sleep-friendly workflow interventions demonstrate that the third category can be reduced and that the second can sometimes be reorganized when clinical status permits [25].

Figure 1 links vulnerability and cumulative disturbance with decisions about clinical necessity and modifiability.

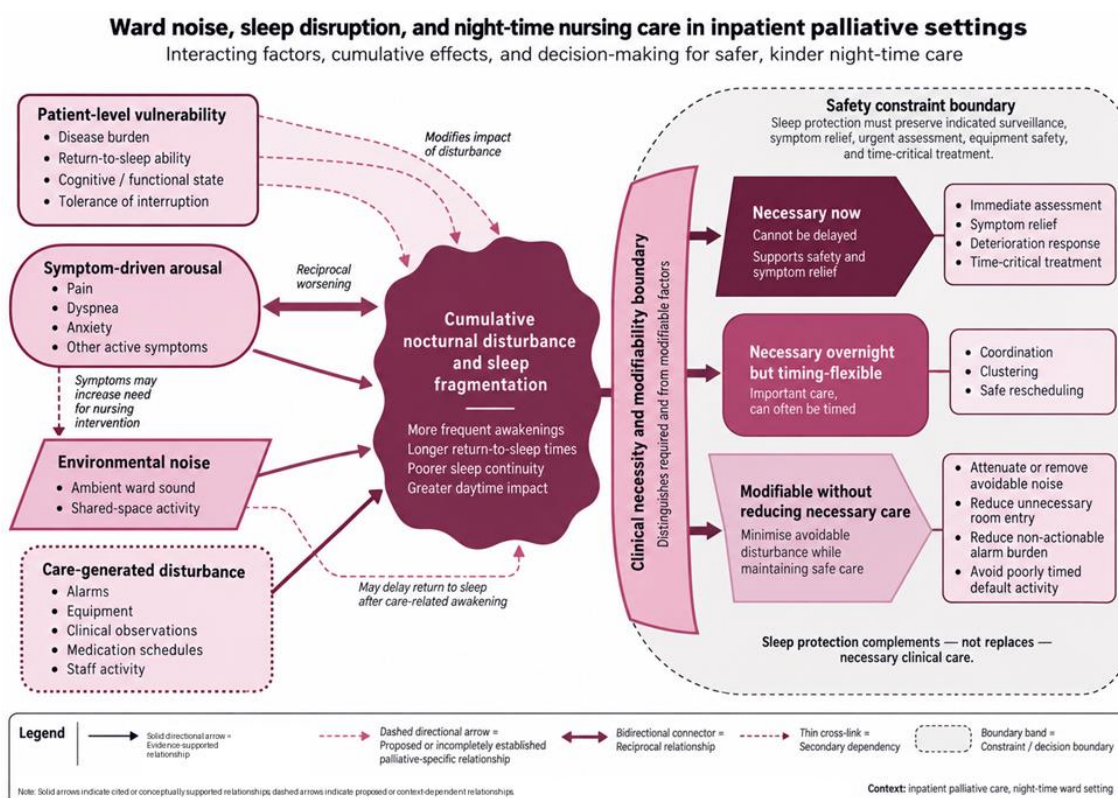


Figure 1. Night-time sleep-protection framework linking patient vulnerability, cumulative disturbance, and clinical necessity in inpatient palliative care

Proposed night-time nursing-sleep framework

The preceding sections suggest that sleep protection in inpatient palliative care should be organized around three simultaneous judgments: patient vulnerability, cumulative disturbance, and **clinical necessity**. None is sufficient alone. A patient may be highly vulnerable to fragmented sleep yet require frequent assessment because clinical instability has increased. Another may be physiologically stable but exposed to repeated low-value disturbance generated by routine ward practices. A third may experience little environmental noise but remain unable to sleep because symptom burden dominates the night.

The proposed framework therefore begins with the patient rather than with a predetermined sleep intervention. First, the nurse identifies whether sleep is currently important to the patient and whether the patient appears especially vulnerable to repeated awakening. Second, the dominant sources of disturbance are distinguished: symptoms, environmental conditions, care-generated interruption, or combinations of these. Third, each proposed or recurring interruption is considered according to clinical necessity and timing flexibility.

This produces different responses. A necessary and time-critical intervention proceeds despite sleep disruption. A necessary intervention whose precise timing is flexible may be coordinated with other care. A modifiable environmental or workflow disturbance should be attenuated when doing so does not compromise safety. A disturbance that cannot reasonably be changed may require compensatory strategies such as symptom optimization, environmental buffering, reassurance, or protection of the next available uninterrupted sleep interval.

The framework is deliberately dynamic. A disturbance cannot be classified once for an entire admission. Deterioration, symptom escalation, patient preference, medication effects, new equipment, or changes in goals of care may move the same activity from one category to another during a single night. The relevant clinical question is therefore repeated: given this patient's current state, does this interruption need to occur now, and if so, can its sleep cost be reduced?

Modifiable and non-modifiable disturbances

The practical distinction between modifiable and non-modifiable disturbance is more useful when treated as a continuum rather than a binary classification. Some disturbances can be removed. Others can only be rescheduled, shortened, attenuated, combined with another intervention, or compensated for after they occur.

At one end are disturbances with little immediate clinical justification: unnecessary conversation near rooms, avoidable equipment noise, excessive lighting, repeated room entry created by poor coordination, or routine tasks whose timing reflects convention rather than current patient need. These are strong candidates for reduction.

A second group contains disturbances that are necessary but reorganizable. Observations, medication administration, repositioning, toileting assistance, equipment checks, and other tasks may still be required overnight while allowing flexibility in timing or coordination. Hospital sleep initiatives suggest that at least some routine nighttime activity can be redesigned when clinical condition permits [25].

A third group contains disturbances that are difficult to modify directly but may be buffered. Acoustic masking illustrates why such strategies must remain conditional. Meta-analytic evidence indicates that white-noise interventions do not produce uniform effects across patient groups or care settings [27]. A potentially useful intervention for one patient may become irritating, disorienting, or ineffective for another.

Finally, some disturbance must be accepted because it arises from necessary symptom relief, urgent assessment, deterioration, safety-related alarms, or unavoidable activity associated with the care of another seriously ill patient. Labeling these events non-modifiable does not imply indifference to sleep. It means that sleep protection shifts from prevention toward minimizing duration, coordinating associated tasks, restoring environmental calm, and reopening a period of rest as soon as clinically feasible.

Nursing workflow redesign

Night-time workflow is a major point at which sleep protection can move from individual intention to organizational practice. Sleep-friendly electronic-order interventions have demonstrated that default schedules can be changed and that nighttime room entry can be reduced when patients are clinically appropriate for less disruptive routines [25]. Restructuring scheduled blood-pressure measurement and other recurring care has likewise shown that modification of nighttime workflow can improve aspects of the hospital sleep experience [26].

Clustering should nevertheless remain selective. Combining medication, observation, repositioning, mouth care, toileting support, and symptom assessment may reduce repeated awakening for a stable patient. The same approach may be inappropriate when a patient requires closer surveillance or when delaying one component would worsen distress. Clustering is therefore not a universal rule; it is an option used when the timing requirements of separate tasks are clinically compatible.

Communication across the night team is equally important [28]. A sleep preference documented at the beginning of the shift has limited value if it is not visible to all professionals entering the room. Handover can include the patient's preferred sleep period, circumstances that justify awakening, scheduled tasks that may be coordinated, and whether environmental modifications are acceptable. The objective is not silence at all costs but fewer unplanned and poorly coordinated disruptions.

Environmental intervention points

Environmental intervention is most effective when matched to the mechanism producing disturbance. Noise-reduction research shows that hospital sound is modifiable, although effects differ by intervention and context [18]. Interventions may therefore operate at several levels: reducing sound at its source, interrupting transmission, altering staff behavior, modifying equipment use, or changing the patient's exposure [29-33].

Light is a separate environmental mechanism. Cancer literature indicates that bright-light interventions can influence sleep-related outcomes, supporting the biological plausibility of daytime light as part of circadian support [34]. This should not be converted into an untested prescription for inpatient palliative units. Instead, the evidence supports attention to a broader 24-hour environment: meaningful daytime light exposure when tolerated, reduction of unnecessary nocturnal light, and avoidance of repeatedly resetting the patient's sleep environment through poorly coordinated nighttime activity.

Individualized sleep promotion

Individualized sleep promotion integrates preference, symptom control, biological vulnerability, environmental exposure, and feasible nursing care. Advanced-cancer behavioral and multimodal studies show that sleep may remain responsive to intervention while patient capacity and intervention burden matter [9, 14, 16]. A bedside plan should identify what prevents sleep, which symptoms predict awakening, whether reassurance or uninterrupted time is preferred, which scheduled tasks are essential, and which environmental measures are acceptable. The plan should be reassessed as function, prognosis, cognition, symptoms, medication exposure, and goals of care change.

Research propositions

Proposition 1: The sleep-disruptive effect of an identical nocturnal event will vary according to patient-level vulnerability, particularly symptom burden and difficulty returning to sleep.

Proposition 2: Reducing a single environmental disturbance will produce limited benefit when symptom-driven or care-generated disturbance remains dominant.

Proposition 3: When clinically compatible tasks are coordinated into fewer care episodes, sleep continuity will improve more than when the same number of tasks are distributed across the night.

Proposition 4: Patient-specific classification of night-time tasks by immediate necessity and timing flexibility will identify more modifiable sleep disruption than generic quiet-hour policies alone.

Proposition 5: Interventions matched to the dominant source of disturbance will outperform undifferentiated sleep-promotion bundles in patient-reported sleep and comfort.

Proposition 6: The effect of environmental interventions will be moderated by patient preference, clinical instability, symptom burden, and the need for staff communication or reassurance.

These propositions require prospective evaluation in adult inpatient palliative populations. ICU and general-hospital studies support the modifiability of selected environmental and workflow factors, but the heterogeneity of existing noise interventions argues against assuming equivalent effects across settings [18].

Results and Discussion

The central contribution of this article is an allocation logic for night-time care. Sleep disruption in inpatient palliative settings should neither be attributed primarily to ward noise nor treated as the unavoidable by-product of serious illness. It emerges from interactions among patient vulnerability, symptoms, the environment, technology, scheduled care, unscheduled care, and the organization of professional work [35-38].

This perspective changes the interpretation of night-time interruption. An awakening caused by opioid administration for severe pain and an awakening caused by unnecessary corridor conversation are not clinically equivalent simply because both interrupt sleep. Nor are all routine observations equivalent: a measurement required because of clinical instability carries a different justification from a default observation performed despite a stable condition and no patient-specific reason for that timing [39-41].

The available evidence also has an important asymmetry. Direct palliative and advanced-cancer research supports the clinical relevance of sleep disturbance and demonstrates that pharmacological, non-pharmacological and multimodal interventions have been studied [1]. Much of the detailed evidence concerning ward noise, observation timing, alarm burden, nursing bundles and workflow redesign comes from general medical, postoperative or intensive-care populations. Those studies establish plausible mechanisms and modifiable processes, but they do not prove equivalent benefit in adult inpatient palliative care.

A second contribution is the distinction between reducing disturbance and reducing care. Successful sleep protection should often permit more intentional care rather than simply less care. A patient whose symptom control is improved before sleep may require fewer reactive encounters later. A coordinated care episode may accomplish several necessary tasks with less fragmentation. A quieter ward may make urgent care less disruptive to neighboring patients. These possibilities shift the target from withdrawal of nursing activity toward better timing, coordination and environmental management.

Practice implications

Nurses can incorporate sleep preference, recent sleep, dominant symptoms, perceived disturbance, and tolerance of overnight contact into routine assessment; nursing evidence favors multifaceted approaches over a single intervention [4]. Units should review repeated room entry, observation and medication schedules, lighting, equipment, communication, and alarm burden. Handover should make patient-specific priorities and time-critical tasks visible. Environmental measures should remain selective and acceptable to the patient, with responsibility shared across nursing, prescribing, monitoring, equipment management, and ward organization.

Limitations

Direct evidence from adult inpatient palliative wards is limited, so several mechanisms rely on cautious transfer from general medical, postoperative, and critical-care research [1]. Studies also vary in definitions and measurements of sleep, noise, intervention exposure, and outcomes. Pharmacological evidence remains limited, environmental interventions may not have uniform effects, and the framework has not been prospectively validated. Future evaluation should account for differences in diagnosis, prognosis, cognition, function, symptoms, and goals of care.

Conclusion

Sleep disruption in inpatient palliative care reflects illness, symptoms, ward conditions, technology, and clinical work. A useful approach identifies vulnerability, the dominant disturbance, the necessity of each interruption, and changes that are safe. Urgent symptom relief and surveillance remain protected; compatible care can be coordinated; avoidable disturbance should be reduced. The objective is the greatest feasible opportunity for rest consistent with comfort, safety, and individual priorities.

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